

**School of Psychology and Speech Pathology  
Faculty of Health Sciences**

**Theory of Change:  
The Client's Perspective on the Nature of Change in Psychotherapy**

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Doctor of Philosophy  
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### **Thesis Declaration**

To the best of my knowledge and belief this thesis contains no material previously published by any other person except when due acknowledgement have been made.

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university.

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## Abstract

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In recent years, research into the client's experience of therapy has been an important and growing area of inquiry. Although a significant amount of research has attempted to ascertain the client's perceptions of therapy, these studies typically use self-reports of satisfaction or change that only allow the client to respond in accordance with sets of predetermined categories expressed in rating scales or questionnaires. Attempts to understand the nature of change in therapy have been predominantly influenced by researchers' theoretical perspectives, in which the client's perspective on therapeutic change has been largely omitted. Therefore, the cardinal consideration of this study is investigation of the factors precipitating and facilitating the occurrence of therapeutic change as perceived by the client. This notion has been supported by a significant body of research, indicating that the client is the single most potent factor responsible for successful therapy outcomes (Bohart, 2000; Duncan, Miller, Wampold, & Hubble, 2011; Lambert & Barley, 2002). The core research question in this study is: *How does therapeutic change occur from the client's perspective and what factors account for that change?* The data were collected via semi-structured interviews and analysed using the Interpretative Phenomenological Analysis (IPA) as the primary methodological approach. The issues central to promoting therapeutic change were studied from the perspective of two client groups, therapist and non-therapist, and from the myriad types of therapies. Results of this analysis showed that there were only minor differences between groups with therapist-participants staying longer in therapy and often seeking therapy for personal development rather than clinical reasons. The results revealed strong elements of shared experience among the therapist and non-therapist clients irrespective of the treatment modality and even the length of treatment. Change was experienced as a gradual development of new structures rather than distinct stage-like phases of transition. One of the most consistent themes to emerge from this study is the pivotal role of relational mechanisms in psychological change. In particular, findings suggest that change was a deeply relational process, in which the therapists' full emotional presence in the context of a safe and stable therapeutic relationship offered not only symptom reduction but also developmentally corrective experiences. Furthermore, research findings suggest that clients experienced

change-promoting, significant moments as a multi-dimensional process of alignment in the cognitive, affective, and bodily domains. The current data indicates that these change-inducing moments of insight emerged spontaneously out of deep and authentic interaction between the client and the therapist. The study also identified a number of factors hindering to the therapeutic process including routinized approach to treatment, premature establishment of goals, provision of quick solutions, imposition of excessive or limited structure, and insufficient attention to termination phase. The research has various implications for the education and training of psychotherapists with regard to the use of theory and technique. The general recommendation of this study is that therapists need to be mindful that clients find mechanised adherence to technique as depersonalising and instrumental. The findings also suggest a need for more careful and effective management of the termination stage of therapy. A comprehensive range of additional suggestions for future research, education, and clinical practice is provided.

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## **PART ONE: LITERATURE REVIEW AND METHOD**

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## **CHAPTER One**

### **Literature Review**

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There is a substantial body of evidence indicating that psychotherapy is highly effective in ameliorating psychological distress (e.g., Barlow, 2001; Duncan, Miller, Wampold, & Hubble, 2010; Norcross & Lambert, 2011; McLeod, 2012). However, in spite of extensive empirical studies spanning the past four decades, the question of how psychotherapy leads to change remains inconclusive. This has been aptly expressed by Kazdin: “Perhaps the most neglected question in therapy research is the mechanisms by which treatment leads to change. Despite numerous studies we still do not know why the treatment works” (2005, p.186). Researchers have attempted to establish the answer to this question by comparing the effectiveness of different models of psychotherapy. Findings from these studies, however, have predominantly indicated the equivalency of therapeutic techniques and approaches in bringing about change (e.g., Lambert & Bergin, 1994; Luborsky, Singer, & Luborsky, 1975; Norcross & Goldfried, 2005; Stubbs & Bozarth, 1994). In keeping with this perspective, Prochaska (1999) argued that if very different theoretical systems produce common outcomes, this might inadvertently indicate the existence of common pathways to change. As a next logical step researchers have turned their focus towards exploring the process of change itself (Elliott, 2008; Greenberg, 2007; Kazdin, 2005).

Research on the nature and principles of change is of critical significance in deepening our understanding of how psychotherapy works. One important component of this understanding is the client’s experience and perspective on change processes in psychotherapy. However, research studies have been typically concerned with exploring the client perspective with regards to outcome and less frequently have prioritized clients’ perspectives on personally meaningful and important factors leading to change in psychotherapy (e.g., Clarke, Rees, & Hardy, 2004; Dale, John, & Messor, 1998; Howe, 1993). For example, if clients are not convinced of the rationale for treatment or value of some experiences or types of change they are less likely to remain in treatment. Also many clients find some aspects of therapy damaging and unless we develop a better understanding of what

those aspects are we will not be able to provide appropriate treatment. Despite the lack of a strong tradition of psychotherapy research that focuses on client perspectives, there always has been curiosity about what goes on in the consulting room. These experiences have been eloquently depicted in autobiographical accounts of medium-to long-term psychotherapy (e.g., Cardinal, 2000; Dinnage, 1989; Sands, 2000). In recent years, therapists and researchers have raised concerns about undervaluing clients' perspectives on factors that facilitate psychological change. This has, in part, been influenced by the growing emphasis on consumer attitudes and expectations in evaluating treatment effectiveness.

The centrality of the client perspective was foregrounded as early as 1936 by Rosenzweig, followed by Lipkin (1948), and has continued to be endorsed more recently by researchers including: Orlinsky and Howard (1987), Lambert (1992); Bergin and Garfield (1994), McLeod (2001), Norcross (2002), Greenberg (2007), Duncan, Miller, Wampold, and Hubble (2010), and Elliott (2010). These researchers began placing more emphasis on the significance of clients' views to the development of the field of psychotherapy research and practice, arguing that their perspectives were relevant on critical evidential, conceptual, and political levels. In viewing the clients as active contributors to the therapy process, these authors advocated investigating the nature of clients' experiences, with particular emphasis placed on these investigations being unrestricted by the researchers' own beliefs and values. This led to the emergence of a growing number of qualitative studies exploring clients' views of individual psychotherapy (e.g., Elliott & James, 1989; Fosket, 2001; Hardy et al., 1999; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; McLeod, 1990; 2001; Macran, Ross, Hardy, & Shapiro, 1999; Richards & Timulak, 2012). These studies have focused predominantly on client-identified events that either facilitate or hinder the therapy process. However, knowledge derived from these studies offers an important but incomplete understanding of the distinctive features and dynamics responsible for generating positive change in psychotherapy. This incomplete state of knowledge makes it difficult for the therapist to know what types of interventions are most likely to generate positive and lasting change. This study aims to uncover some of the specific constituents of change through a detailed exploration of clients' experience of the processes of change in psychotherapy.

This chapter will present a background to this study by providing a detailed overview of the current literature on the client's experience of psychotherapy. This overview will begin with an exploration of the client's perspective in psychotherapy research, discussing empirical, conceptual and political reasons for neglecting the client's perspective, as well as evidence for its consideration. Next, the review will provide a summary of the current state of research on the client experience of psychotherapy, describing the main areas of investigation, including methods for assessing client change, the key findings of these enquiries, and their contributions to understanding the therapeutic process of change. This will be followed by the review of selected models on the course of change clients follow during therapy. The chapter will conclude by identifying the existing gaps in the literature and providing the rationale for the direction of the current study.

### **The Client's Perspective: Why is it Significant?**

Historically, psychotherapy researchers paid scant attention to how clients' experiences of psychotherapy contribute to our understanding of the therapeutic process. Instead, research has mostly focused on the therapist's techniques, skills, competencies, and perspectives on the therapeutic process. Neglect of the client's perspective may have partly originated from the psychoanalytic concept of unconscious mental processes that assumed that patients were unaware of underlying forces that determined their behaviours (e.g., Bohart, 2004; Dreier, 2008; Mackrill, 2009). This focus meant that clients were not seen as capable of forming significant evaluations and reflections on the change processes. Another historically influential paradigm that devalued the client's perspective is behaviourism. Because the main emphasis is placed on observable behaviours and their environmental concomitants, the client's reports on their thoughts, feelings, and perceptions were considered to be of lesser importance (e.g., Dreier, 2009; Kazdin, 2007). Further to this, there are a variety of reasons for researchers' diminished interest in the client's reflections and judgments on their experiences. These reasons include: 1) the client's state of psychological distress may make their evaluations and perspectives unreliable; 2) the client's reported experiences are likely to be influenced and distorted by their negative mental states (e.g., according to cognitive theory, depression is likely to determine the way clients see and feel about interventions being offered to them); 3) psychological difficulties compromise the accuracy of recall; 4) clients are seen as having a less differentiated view of the therapy process than therapists; and 5)

clients' lack of expertise is assumed to make them unreliable in distinguishing and subsequently critically reflecting on the central components of therapy (e.g., Horvath, 2001; Macran et al., 1999; Shapiro et al., 1994; Stiles, 2009).

In addition, there are strong political, economic, and social forces that have inadvertently shaped the way in which research is conducted. Over the last two decades, the medical model of mental illness has dominated the field of psychotherapy research. According to the "drug metaphor" underlying this paradigm, the client is a passive recipient of ministrations of the practitioner whose expertise dictates success or failure of any given treatment (Duncan et al., 2010). This inevitably invites a conclusion that clients' insights are at best of secondary importance. Thus, the goal of psychotherapy research typically centred on exploring techniques of the therapist and identifying what renders them successful in generating positive treatment outcomes. Further to this, the medical model of mental illness and clinical trials in medical research has predominantly focused on demonstrating the effectiveness of various kinds of psychotropic medication (Macran et al., 1999; Stiles, 2009; Wampold, 2001). As a consequence, researchers began facing pressure from governments, health care agencies, and other funding bodies to produce scientific evidence of psychological treatment efficacy largely conducted to the exclusion of clients' perspectives.

**The importance of incorporating client perspectives.** Change is a focal point of psychotherapy, and the goal of all psychotherapy models, yet there is little agreement on what constitutes therapeutic change (Bohart & Tallman, 1999; Bohart, 2000; Elliott, 2008; Greenberg, 1991; Kazdin, 2005). Therapists define change in a number of ways, including ego strengthening, personality restructuring, cognitive restructuring, reduction of symptoms, and addressing existential anxieties. While the therapist's expertise is instructive in developing understanding of the constituents and mechanisms of change, client factors appear to be equally significant. This is particularly evident in the context of the multitude of studies and meta-analyses that have repeatedly shown that the client is the single most important factor responsible for successful outcomes in therapy (Bohart & Tallman, 1999; Gold, 1994; Lambert & Barley, 2002). For instance, a recent overview of outcome studies conducted by Cooper (2008) showed client factors to be of greater importance in determining treatment outcome than the combination of the therapeutic relationship, therapist skills, and therapist attributes. Research has also consistently showed that positive

treatment outcome is largely determined by the client's experience of the therapeutic relationship (e.g., Duncan et al., 2010; Senf & Heuft, 1993).

These research findings specifically indicate that the resources clients bring to therapy and factors that influence their lives outside of therapy are important in determining therapeutic change (Bohart & Tallman, 1999; Dreier, 2008; Lambert & Barley, 2002; Mackrill, 2009; Wampold, 2001). Lambert's (1992) extensive review of psychotherapy research revealed four main therapeutic factors contributing to positive treatment outcome. The largest variable was that relating to client factors, which account for 40% of the variance of outcome. These factors, also known as extratherapeutic factors, refer to the client's life circumstances. They include client strengths, supportive elements in the environment, as well as chance events (Asay & Lambert, 1999). The second largest variable accounting for 30% of successful therapeutic outcomes was the client's perception of the therapeutic relationship. This variable, commonly referred to as the therapeutic alliance, comprises the client's relationship with the therapist, the client's capacity to work in therapy, and the client-therapist agreement on the tasks and goals of therapy (Asay & Lambert; Bahelor, 1991; Gaston, 1990; Safran & Muran, 2000). This finding is supported by a growing number of studies showing the client's rating of the therapeutic alliance to be the single best predictor of treatment participation and outcome (e.g., Bahelor; Duncan & Miller, 2000; Gaston, 1990; Horvath & Symonds, 1991; Norcross & Lambert, 2011; Safran & Muran, 2000). The third factor consists of client levels of expectancy, hope, and placebo effect. This variable contributes 15% to positive outcome and consists of the client's perceptions of treatment credibility, the installation of hope, and the knowledge of being helped. The fourth factor is the specific model or technique, which accounts for 15% of outcome variability. Upon analysis of these findings, Norcross and Lambert (2011) concluded that whilst research fails to demonstrate the superiority of one treatment method over another, it is the elements common across all models of treatment that explain a successful outcome – namely the innate resources of the client, the quality of the relationship, and the hope for improvement.

Attribution research also suggests that congruence between therapist and client theories of problem causality and change contribute to positive outcomes (Atkinson, Worthington, Dan, & Good, 1991; Bohart, 2000; Claiborn, Ward, & Strong, 1981; Duncan & Miller, 2000; Warthinton & Atkinson, 1996). A number of authors have



argued that the clients will generally have their own theory about their psychology, life situations, difficulties, and how to resolve them (Bohart, 2000; Gold, 2000; Held, 1991; Mackrill, 2008). This has been confirmed by studies showing that pre-existing beliefs about the problem and change process significantly influence client acceptance of a particular procedure and are one of the major determinants of its usefulness in engendering change (Elkin, 1999, Witt & Elliott, 1985; Wampold, 2006). For example, Elkin, in the review of the Treatment of Depression Collaborative Research Project (TDCRP), noted that a client who believed their condition to be biological in nature, and who received pharmacological treatment had better results and stayed longer in treatment. She concluded that it was the congruence between the client's concept of change and the treatment that resulted in a stronger therapeutic alliance, longer duration in treatment, and improved treatment outcomes. This data, while stressing the centrality of a collaborative approach between therapist and client, led some authors to advocate for therapy to be conducted within the client's frame of reference and with emphasis on the client's theory of change (e.g., Hubble, Duncan, & Miller, 1999; Bohart & Tallman, 1999). They define client theory of change as: 1) client resources, skills, and agency in and outside of therapy; 2) client perception and experience of the therapeutic relationship; and 3) client perception of the presenting complaint, its causes, and how therapy may best address the client's goals and expectations (Hubble et al., pp. 431-2).

Another reason for researching the client's subjective views of the therapy process is evidence derived from studies that examine the client's experiences of therapy. These studies have generally shown clients to be active agents who use therapy in their own way, for their own requirements, and who seek to control the meaning of their own experience and the meanings that others give to that experience (Elliott & James, 1989; Dreier, 1991, 2008; Duncan, 2004; Duncan, & Moynihan, 1994; Gold, 1994; Howe, 1993; Knox, 2008; Knox & Cooper, 2011; Lambert, 1992; Mackrill, 2007, 2009; Manthei, 2007; Rennie, 2001; Bohart & Tallman, 1999). There has also been a substantial amount of data accumulated over the past two decades that indicates discrepancies between therapist and client perceptions and evaluations of various aspects of therapy (Elliott, 2008; Rennie, 2001). These findings indicate a high level of inconsistency between therapist and client assessments of how therapy is progressing and what aspects of the intervention

have been helpful. For example, Metcalf, Thomas, Duncan, Miller, and Hubble (1996) reported disagreements between therapists and clients on what accounts for progress in treatment, with clients' prioritizing the therapeutic relationship over technique. Similarly, Elliott and James' (1989) review showed poor agreement between therapists, clients, and independent observers as to what constitutes effective therapeutic intervention. This is further compounded by the fact that a significant level of the client's experiences in therapy remains covert, particularly as related to positive and negative therapeutic impacts, which are commonly underreported by the client (Henkelman & Paulson, 2006; Maione & Chenail, 1999; Manthei, 2007; Rennie, 1994; 2000). Levitt and Rennie (2004) also discovered that clients offered significant information in post-therapy interviews that they withheld from therapists at the time of treatment.

In summary, these findings point to the centrality of the client's perspective in attempts to better understand what accounts for positive change in therapy. This is particularly relevant in the light of common factors research, which views the client as the most potent source of therapeutic change. It is the client's perceptions of the goals, the tasks of therapy, and the relationship with the therapist that are to be a major determinant of the successful treatment outcome (Hubble et al., 1999). In support of this tenet, Lambert (2004) stated that: "It is the client more than the therapist who implements the change process. If the client does not absorb, utilize, and follow through on the facilitative efforts of the therapist, then nothing happens" (p. 825).

#### **Conceptual and political contributions about client's perspective.**

There is a growing literature concerned with conceptual and political reasons for incorporating clients' perspectives in psychotherapy research. Mounting research evidence supporting the significance of client factors in influencing positive treatment outcome further justify investigation into clients' understanding of the conditions that enable their active engagement in psychotherapy treatment (e.g., Duncan et al., 2010; Lambert, 1992; Bohart & Tallman, 1999). This becomes even more significant, in light of recent rapid political and economic changes that influence how psychotherapy is delivered. With increased demand and limited availability of psychotherapy services, there is greater pressure for providers to

justify their services by showing evidence of clinical effectiveness as well as demand (Macran et al., 1999).

Quantitative research, while dealing with larger study groups, provides essential information on patterns, trends, and tendencies occurring within an investigated population. Qualitative research, on the other hand, stands as a valuable adjunct in uncovering more in-depth, individual patterns of behaviours, thus generating a more complete picture of studied phenomena. Specifically, one of the main conceptual reasons for increased application of qualitative approaches into psychotherapy research is the current domination by the “drug metaphor” and medical model of psychological disorders that predominantly lends itself to the application of controlled experimental methods to psychotherapy research. Clinical practice is not aligned in an exact way, however, to the medical model of psychological disorders (e.g., Goldfried & Wolfe, 1996; Stiles, 2009). Instead, research findings outline much more complex processes within the therapeutic encounter than those that can be delineated by the medical model alone. Adding qualitative investigations into the clients’ experience of therapy can illuminate this gap between research evidence and clinical practice. The in-depth subjective details derived from qualitative studies can help to make more accurate inferences on quantitative empirical findings.

Qualitative, narrative, and case study methods of investigation are important in investigating psychotherapy processes and their effectiveness (Stiles, 2009). These methods of enquiry are suitable for investigating phenomena which are complex and cannot be easily controlled by investigators; that is, where variables are not easily isolated and causal chains are not linear (Stiles, 2009). While quantitative research provides the statistically significant empirical evidence that enables assessment of the efficacy of treatment, it is the qualitative findings that focus on individual differences which allow for comprehensive inferences about statistical data and prevention of its mechanical application (Butler & Strupp, 1986). As Butler and Strupp have cogently argued: “Psychotherapy consists of behaviours and vocalizations whose influence depends on the meanings attributed to those behaviours and vocalizations by the participants” (p. 32). One way of addressing these methodological challenges to understanding the complexity of subjective interactions within psychotherapy processes lies in utilizing qualitative methods.

Similarly, adding a qualitative dimension into psychotherapy outcomes research can offer a more comprehensive picture and contextual understanding for interpreting these findings. For example, one of the main forms of studying the treatment outcomes of psychotherapy is randomized clinical trials (RCTs). Stiles (2009), in his evaluation of psychotherapy outcome research, argued that in RCTs, compared treatments are likely to differ with respect to both independent (manipulated) variables and dependent variables that cannot be evenly distributed across the groups (randomized). That is, in order for RCTs to have statistical significance each tested group needs to receive a different treatment, but members within each group need to receive exactly the same treatment. The second requirement, he argued, cannot be fulfilled in psychotherapy research because clients in a psychotherapy treatment condition do not receive the same treatment. An explanation proposed by Krause and Lutz (2009) is that this is due to “causal entanglement”, which means that “Outcome – relevant treatment, therapist, and patient input variables or types- casually influence each other” (p. 74).

Krause and Lutz described this confounding condition as responsiveness: our behaviours are affected by the context in which they emerge, as well as by the behaviours of others (2009). One of the cornerstones of therapeutic intervention, irrespective of treatment modality, is the therapist’s attunement to emerging material and ability to promote the client’s progress. Therefore, the therapist’s responsiveness may inevitably work to defeat any differential treatment effects (Stiles, 2009). To complicate matters further, some research shows that therapists differ in their responsiveness and some are far more effective than others (e.g., Elkin, Falconnier, Martinovich, & Mahoney, 2006; Wampold, 2006; Wampold & Brown, 2005). These findings indicate that therapists deliver treatment differently to different types of clients, whilst at the same time, clients will affect the way treatment is implemented (Bohart & Tallman, 1999). One contribution that qualitative research can make into untangling these factors is to explore clients’ perspectives, where individual differences can be comprehensively studied.

Building on previous points, Castonguay (2011) has argued that in order to better guide clinicians in their practice, research needs to respond to the complexity involved in investigating psychotherapy processes and effectiveness. He stated that, despite the tradition of a scientist-practitioner model in applied psychology, the relationship between psychotherapy research and clinical practice is tenuous at best.

In recent years, however, more effort has been placed on establishing stronger links between research and clinical practice. Some of these include an “effectiveness research” design for monitoring the external validity of RCTs and development of treatment manuals. These strategies undoubtedly strengthen evidence-based practice, but they are largely representative of the “top-down” approach, in which researchers generate knowledge that is subsequently theorized and disseminated to practitioners.

Castonguay (2000) referred to this process of control as “empirical imperialism”, where it is a researcher who determines what warrants studying in order to improve practitioners’ understanding of psychotherapy. In an attempt to bridge that gap, some authors (e.g., Castonguay, 2002; Elliott, 1983; McLeod, 2000) have argued for research to incorporate and encompass client perspectives through both quantitative measures of symptoms and the use of qualitative approaches. Thus, verification of the accuracy of clinical theories can be achieved through detailed and systematic observations of phenomenon under investigation. This information can guide theorists and clinicians as to what needs to be modified, corrected, or elaborated upon. Further to this, Roussos (2013) pointed out that it is qualitative change assessment that remains “a fundamental standard for the development and validation of psychotherapy research as a scientific discipline” (p. 503). In agreement with this, Ogles (2013) argued that, in order to advance the assessment of change, a paradigm shift is needed which will be grounded in the incorporation of both qualitative and quantitative forms of investigation.

Apart from conceptual validity, incorporating clients’ perspectives into psychotherapy research has strong political reasons. The current health economy puts demands on psychotherapy services to compete for funding; in order to be successful services need to collect and disseminate evidence showing that the therapy provided is of benefit to the clients (Wampold & Brown, 2005). As a result, organizations are adopting and implementing various outcome measures to evaluate and account for the services provided to clients. For example, in the UK the National Health Service Patients’ Charter for Mental Health Services began promoting a model of primary care that is responsive to clients’ needs and views (Macran et al., 1999). This has occurred not only within areas of mental health but in the broader areas of health and social care (Department of Health’s Research Governance Framework for Health and Social Care as cited in Morris, 2005).

Similar trends prevail within health systems in the US and Australia, where funding from government and health insurance companies for mental health treatment is rapidly diminishing. Correspondingly, agendas are focused on clinical effectiveness, as there is a growing recognition that clients fail to comply with provider services if they feel that their needs and expectations are not being met. In addition, over the past thirty years the mental health advocacy movement developed, which focuses on reducing stigma attached to mental health problems as well as improving services available to individuals with mental illness (Funk, Minoletti, Drew, Taylor, & Saraceno, 2005). They have been able to influence governments on laws and policies related to mental health as well as facilitate social integration of people with mental disorders.

This recent increased emphasis on accountability in health care has led to the “empirical validation” of psychotherapy treatments. These validations, however, rarely factor in client views on contributions to the effectiveness of therapy. At a time when insurance companies fund a limited number of “empirically validated” treatments, consumer and provider choices of services being offered will largely diminish (Wampold, 2006). Thus, it seems particularly important to allow the consumer to have a voice in influencing what kinds of treatment they will be entitled to. This partly can be achieved by increasing research efforts to investigate client views on what promotes therapeutic change and successful outcomes. Knowing client views on what promotes therapeutic change has the potential to increase customer satisfaction (Elliott & James, 1989; Hubble et al., 1999). Thus, learning what the client has to say about their own experiences of change will provide practitioners with critical information about how best to assist clients in achieving their goals.

**Client’s overall levels of satisfaction.** Numerous meta-analyses have established that therapy is beneficial, with a treatment effect size of 0.8 for treated clients compared to untreated ones (e.g., Casey & Berman, 1985; Duncan et al., 2010; Lambert & Ogles, 2009; Smith, Glass, & Miller, 1980; Weiss, Alicke, Klotz, 1987). For example, Seligman, in his highly influential Consumer Report on the effectiveness of psychotherapy (1995), showed that clients benefit substantially from psychotherapy, but also that they found longer-term treatments far more beneficial compared to short-term interventions, and that they regarded psychotherapy alone just as successful as psychotherapy combined with medication. This is also reflected

within research data showing that the vast majority of clients are satisfied with their experiences of therapy, with satisfaction levels ranging from 76 to 96% (Bende & Crossley, 2000; Deane, 1993; Leuzinger-Bohleber, Sthur, Ruger, & Beutel, 2003). While client satisfaction is often associated with greater symptom relief (Evans et al., 2002; Gatson & Sabourin, 1992; Hafkenscheid, 2009; Watson & Greenberg, 1996), studies show that the validity of client satisfaction measures and client perceived improvement cannot be equated with formal measurements of change in psychopathology (e.g., Gatson & Sabourin, 1992; Lambert, Salzer, Bickman & Kendall, 1998). However, there are not many instances, both within research and clinical settings, where these measures are used concurrently to complement each other (e.g., Bickman, 1997; Seligman, 1995). This is partly induced by cost-containment strategies that have accelerated the use of consumer satisfaction measures, which are quicker and cost effective ways of verifying treatment effectiveness.

Studies have shown either greater client satisfaction ratings for those with clinically significant changes (Ankuta & Abeles, 1993), or conversely, minimal to no relationship between satisfaction ratings and psychopathology change (Campbell, 1997; Pekarik & Wolff, 1996). This is partly related to the fact that these measures do not typically control for response sets, like social desirability, and do not contrast their findings against multiple perspectives (e.g., therapists, outside judges, community criteria). For example, correlational studies show high outcome variance between multiple informants (client, therapist, and parent/s) (e.g., Lambert et al., 1998). In addition, some studies found that while trait dependent variables (social desirability) were not correlated with measures of social satisfaction, questionnaires completed at home produced lower and more varied satisfaction ratings (e.g., Boulet & Boss, 1991; Deane, 1993). One of the possible implications is that while trait dependent variables may not generate biases in clients' evaluations, contextual or proximity factors may determine the accuracy of accounts.

The methodological issues associated with self-report measures call for a more comprehensive and multidimensional approach to studying the client experience of psychotherapy processes and outcome. This has been long advocated within the psychotherapy field. For example, as early as 1977, Strupp and Hadley proposed a tripartite conceptual model of mental health and therapeutic outcomes, examining the effects of psychotherapy from the perspective of the society, the

individual, and the mental health professional. In addition, Safran (2013) has drawn attention to the fact that two clients who undergo the same treatment and show the same changes on standard outcome measures are likely to experience different types of change. Outcomes indicated by standard measures may be describing types of change that are radically different in nature. Most importantly, however, such measures provide no substantive information on the actual experience clients have in therapy, which is fundamental in establishing causality between improvement and satisfaction. Thus, in order to better understand processes that govern psychological change and provide a much-needed link between research and clinical practice, we need methodologically pluralistic approaches to psychotherapy research with greater focus on the client's experience of psychotherapy.

### **The Client's Experience of Therapy: Overview of Research**

Over the past decade there has been a swift reaction to the under-emphasis on client experiences of change in therapy (e.g., Duncan & Miller, 2000; Heatherington, Constantino, Angus, Friedlander, & Messer, 2012; Macran et al., 1999). Substantial research explorations have generated evidence in support of viewing the client as the 'site of change' (Greenberg, 2007). However, the most recent qualitative investigations into the client's experience of change confirm the difficulties in reaching consensus about the main constituents of psychotherapy change. Rousso explains this in the following way: "Change has been an important, yet elusive, concept since the origins of psychotherapy research. Researchers are still trying to find answers to the following questions: What is change? How can change be measured? Why and how does change occur?" (2013, p. 503). While change in psychotherapy is most broadly understood as a form of psychological growth stimulated by treatment, the difficulty lies in finding empirically supported principles of change (Rosen & Davison, 2003). It is therefore important to continue decoding the client's perceptions of change in hope of generating a list of client-identified principles of change (e.g., Greenberg, 1999; Hill, Chui, & Baumann, 2013; Rousso, 2013).

The client's experience of therapy has been typically researched by identifying which aspects of treatment are of significance to the client (Elliott, 2008). These investigations can be broadly divided into two groups, one focusing on more general types of change by inquiring about helpful and hindering aspects of therapy,



and the other exploring more specific aspects of change by enquiring about various significant moments (e.g., Bende & Crossley, 2000; Clarke, Rees, & Hardy, 2004; Greenberg, 2007; Klein & Elliott, 2006; Manthei, 2007; Paulson, Truscott & Stuart, 1999; Timulak, 2010). Another body of research on the client's experience of psychotherapy focuses on the role client agency and expectancy play in generating and sustaining therapeutic change (e.g., Dreier, 2008; Makrill, 2008; Rennie, 2001). The underlying premise of investigation into each domain is that they contain the sought-for effective ingredients of successful treatment. Client-identified themes that arose from these investigations were predominantly about change in thinking, with greater awareness of the problem, new perspectives, new tools and strategies as well as greater self-reflection, creativity, and improved personal and professional relationships (Carey et al., 2007; Hannah & Ritchie, 1995; Leuzinger-Bohleber et al., 2003). Readiness for change and strength of the relationship with therapist were also stressed as being equally important.

There have been, however, no comprehensive reviews of research into the client's experience of therapy since the Elliott and James (1989) and McLeod (1990) reviews. This chapter will provide a comprehensive review of existing research on the client's experience of therapy. Studies have been organized into sections reflecting main areas of the research. These are: the client's experience of change in therapy, helpful and hindering factors, significant moments, and client agency and expectancy.

**Client's experience of change in therapy.** Studies of the client's experience of change in psychotherapy focus on identifying change across cognitive, affective, and behavioural dimensions. However, the exact mechanisms of these complex processes remain largely elusive to psychotherapy research. Despite the plethora of theories that explain processes of change in psychotherapy (Highlen & Hill, 1984; Mahoney, 1991; Rice & Greenberg, 1984), and the considerable amount of research investigating clients' experience of change in psychotherapy (Elliott, 1991; Elliott & Shapiro, 1992; Knox, Goldberg, Woodhouse, & Hill, 1999; Rennie, 1994; Timulak, 2007; Vanaerschot & Lietaer, 2007), there are still gaps and inconsistencies between what theory predicts and how this maps on to the actual client experience in therapy. There is also insufficient knowledge about the mediational processes responsible for translating therapeutic change into postsession and post-treatment change (Elliott, 2008). It is therefore necessary to continue

exploring the potential range and form of client experiences in order to identify the elements of therapy process, or curative factors that are most relevant to therapeutic change.

Examination of psychotherapy theories revealed that change is seen as either primarily driven by cognitive or affective processes (e.g., Cooper, 2008; Highlen & Hill, 1984; Greenberg & Rhodes, 1991; Mahoney, 1991). Goldfried's (1991) meta-synthesis of theories of change in psychotherapy revealed the following factors central to the facilitation of change: (a) giving clients hope, (b) facilitating clients awareness by helping them link thoughts and feelings, (c) promoting corrective experiences, (d) providing ongoing reality testing, and (e) establishing a good therapeutic relationship and solid alliance. He further claimed that the end point of the change process is characterized by improved self-efficacy and self-esteem. Even though there appear to be some common elements, research suggests a lack of uniformity in the change processes, with change following different trajectories for different clients under differing circumstances. Change does not seem to follow a linear growth curve, but instead fluctuates over time. It is still unclear which factors influence these fluctuations. If change is not a unitary process, it is critical for research to continue its investigations with the aim of describing various change processes rather than trying to discover a singular change process (Hill & Corbett, 1993).

There are a growing number of researchers who have more deliberately turned their focus into the investigations of patterns of change (e.g., Carey et al., 2007; Cummings & Hallberg, 1995; Cummings, Hallberg, & Slemon, 1994; Hill & Corbett, 1993; Holmes & Kivlighan, 2000). For example, Cummings et al. discovered three different patterns of client change, including: (1) a consistent pattern, characterized by steady improvement in self-understanding and resolution of painful feelings, the development of personal theories of change, the maintenance of hope and processing of insight between the sessions; (2) an interrupted pattern in which initial improvement is interrupted by a setback and reversion to a state of self-doubt; and (3) a minimal change pattern characterized by initial minimal change, followed by a plateau of no change with active avoidance of painful feelings, no personal theory of change, and an inability to process material at deeper levels – which is commonly present in clients reluctant or ambivalent about therapy (1994). However, the small number of participants (10 female Caucasian undergraduate

psychology students) and use of novice counsellors who were seeing the first “real” client may pose some threat to the validity of the findings. It is quite likely that clients of more experienced counsellors would show different pattern of change. Nevertheless, other studies also showed clients’ experience of change as following either a consistent or interrupted pattern (Heppner, Rosenberg, & Hedgespeth, 1992; Hoyt, Strong, Corcoran, & Robbins, 1993).

A subsequent study, which investigated change in a longer term counselling, found only consistent and interrupted patterns of change (Cummings & Hallberg, 1995). They argued that the minimal change pattern was absent in longer-term counselling, due to less client ambiguity regarding treatment and greater commitment to change. Interestingly, patterns of change in longer-term counselling were consistently characterised by a strong and positive relationship with the therapist, unlike in short-term counselling, where clients were either more task-focused or more dependent on the counsellor (e.g., thinking about the counsellor between sessions, feeling close to the counsellor, or worrying what the counsellor thought of them, all of which indicated stronger transference) (Cummings & Hallberg, 1995; Cummings et al., 1994).

Analysis of change in longer term counselling also revealed that a focus on presenting issues prevailed in the early stages of therapy, while the focus changed to deeper issues (e.g., relationship patterns) in the later stages of treatment (Cummings & Hallberg, 1995; Cummings et al., 1994). Clients’ preoccupation with the therapeutic relationship was of highest frequency at the beginning and towards the end of treatment, whereas the middle stages were characterized by events associated with growth and insight. Holmes and Kivlighan’s (2000) study echoed this by showing that the “relationship-climate component” was higher at the beginning and at the end, while the ‘problem definition-change’ components showed a linear increase throughout the course of treatment.

More recent studies continue to support the notion that a singular change process does not exist. For example, one study did not describe change as a series of stages, but instead spoke about a period of negativity, followed by a sudden moment of change, and finally a protracted period of positivity (Carey et al., 2007, p. 183). This is, however, in contrast to Clarke, Rees, and Hardy’s (2004) findings showing that clients who have completed cognitive therapy move through the stage-of-change model. These incongruent findings may be a result of sampling size, degree of

homogeneity, type and length of treatment, as well as degree of structure of the interview. It may also be that change is a more complex and non-linear process, which cannot be fully and accurately conceptualized by a stage model. Perhaps the phenomenon of change as described by clients cannot be accurately reflected within one model or theory. Clients' recall of the change processes may also be closely tied to the form of treatment received. For example, more sequential forms of treatment, such as cognitive-behavioural therapy, may lend themselves to stage-like change recall more readily than psychodynamic forms of therapy.

Another study used the Assimilation of Problematic Experience Model to explain how clients build on and make use of their experience. Results suggested that, over time, the clients' problematic experiences are integrated into their existing schemas (Stiles et. al., 1990). While this study only examined change during therapy, it could be assumed that the same processes extend into the post-therapy stage. This would explain the continuous process of integration and internalization of therapy generated learnings. In psychoanalytic literature, this concept is described in terms of the development of the 'self-analytic' function, enabling the client to internalize the therapist and keep experiencing the therapeutic process post-therapy (e.g., Orlinsky, Geller, Tarragona, & Farber, 1993; Schlessinger & Robbins, 1974). The intensity and the length of therapy may play a facilitative role in this process. For instance, in a study conducted by Leuzinger-Bohleber et al. (2003), clients who had completed longer-term psychoanalytic therapy formed stronger internal representations of therapy and the therapist. Similarly, in their investigation into the client's representations of psychotherapy outside of sessions and post-therapy, Orlinsky and colleagues discovered that higher frequencies of therapist representations were linked to greater availability of those representations at the time of distress; this in turn was linked to a positive outcome. Research findings indicate that this process of identification and internalization generates more permanent changes in personality structures that can then be readily re-activated post-therapy (Orlinsky et al., 1993).

Studies investigating the client's experience of change post-therapy have showed change to be an ongoing process that continues long after the end of treatment, with improvements being reported anywhere between two to ten years post-therapy (e.g., Bende & Crossley, 2000; Hsu, Crisp, & Callender, 1992; Kantrowitz, Katz, Paolitto, 1990; Leuzinger-Bohleber et al., 2003; Orlinsky et al., 1993). Leuzinger-Bohleber and colleagues (2003) noted that six and a half years

after completing therapy, positive and stable psychic change was maintained by 70-80 per cent of participants. The development of insight and ability to handle problems adequately were amongst most prevalent post-therapy changes (Bende & Crossley, 2000; Leuzinger-Bohleber et al., 2003). There is also evidence, that along with the continued post-therapy changes, clients' understanding of the experience and its impact on their lives undergoes modifications. For instance, Feifel and Eels (1963) showed that four years post-therapy, clients' tendency to view changes as mainly positive (which was prevalent at termination) significantly decreased, along with increase in their ability for more critical reflection. That is, they were more likely to critically evaluate therapists' characteristics and technique and provide constructive suggestions on adjustments to the therapy process.

Another study noted an increase in reporting of harmful effects in therapy in the first four years after termination; however, this tendency decreased dramatically for those who were 11 to 20 years post-therapy (Buckley, Karasu, Charles, 1981). The findings were explained in terms of the 'dissolution of transference' effect and increased socio-centric orientation. Thus, over time, clients resolved the transference by gradually recognizing the relationship with the therapist as a representation of earlier significant relationships. This was accompanied by the clients' progression towards and greater engagement with their own social group. These findings suggest that retrospection and distance enabled clients to develop a more accurate perception on their experience of therapy. This could be partly explained by the fact that it is only with time that clients can judge the applicability of new learnings and accurately assess change.

Researchers also tried to understand the client's experience of change in therapy within cross-cultural contexts (Chang & Berk, 2009; Cherbosque, 1987; Jock, Bolger, Olivera, & Roussos, 2013; Krause, Altimir, & Horvath, 2011). Such investigations are of great significance, particularly as there has been a very limited interest in cross-cultural client perceptions of therapy. In their comparative study, Jock and colleagues explored the subjective experience of therapy amongst former clients from Argentina and the United States. These two cultural groups differed in their experience of therapy setting, the therapist's interventions, and types of changes resulting from therapy. Specifically, Argentine clients identified change in interpersonal, vocational/educational, general functioning, and a decrease in symptoms with higher frequency than their US counterparts. This finding was

explained by the commonplace nature of psychotherapy in Argentina, particularly psychoanalysis and psychodynamic psychotherapy.

Most importantly, these comparative cultural findings indicate that the process of change is largely dependent on the social context (Jock, Bolger, Olivera, & Roussos, 2013). Despite similar reasons for seeking treatment (e.g., adjustment to a life event/s or symptom reduction), for the clients in these two cultures the process of change differed significantly in terms of length, frequency, and intensity. It appears that social and cultural norms are salient in determining the need for and the motivation to seek treatment, as well as the length and frequency with which clients engage in therapy. This research indicates that the client's perception of change is largely shaped by social and cultural attitudes towards psychotherapy. Perhaps the degree to which acculturation occurs within a "therapy valuing" environment will determine how likely, for how long and presumably with what outcome clients experience treatment. The latter implication lies in the ongoing nature of change which in a "therapy valuing" environment may simply gain greater reinforcement, application, and meaning post therapy.

These findings contribute to our understanding of the mechanisms of change during and post-therapy. They show that change processes lack uniformity in that some changes were described as being consistent and linear, while more varied at other times. For example, research indicates that different patterns of change are experienced in short and long-term counselling. These studies also indicate change processes lack uniformity at the cultural and individual levels, therefore necessitating further studies delineating patterns of change and its predetermining factors for different client groups.

***Therapist's experience of personal therapy.*** Therapists' views of their own personal therapy form another dimension of studies on clients' experiences of psychotherapy. Personal therapy is relatively common amongst mental health professionals with some sub-group variance (Orlinsky Rønnestad, Willutzki, Wiseman, & Botermans, 2005; Norcross & Guy, 2005). Therapists typically see their own therapy as being highly significant in their development, with particular emphasis on improvement in their therapeutic skills. However, research findings are inconclusive with regard to the impact of a therapist's personal therapy on treatment outcomes for their patients. Two other neglected elements that warrant further investigation include the mechanisms by which personal therapy impact therapists'

practice and whether therapists' experiences of therapy differ from those of other client groups, and, if so, in what ways.

Research indicates that at least 75% of mental health professionals have undergone personal therapy (Dearing, Maddux, & Tangency, 2005; Orlinsky et al, 2005; Norcross & Guy, 2005). The benefits of personal therapy were profound, with more than 90% of therapists reporting personal improvements, and more than 75% recognizing a significant influence on their development as a therapist (Orlinsky, Botermans, Ronnestad; 2001). Orlinsky et al. (2001) in a survey of 4 000 psychotherapists, found that personal therapy was ranked as important as direct contact with patients and formal supervision, a finding that is consistent with previous studies of much smaller samples (e.g., Morrow-Bradley & Elliott, 1986; Rachelson & Clance, 1980; Skovholt & Ronnestad, 1995).

At the same time, research shows that between 20-25 % of therapists across all professions and training levels do not engage in personal therapy (e.g., Norcross & Guy, 2005). Some studies point to the gender differences, with lower numbers of male therapists seeking treatment (e.g., Pope & Tabachnick, 1994). This tendency was also reflected in a study where fewer depressed male psychotherapists (61%) sought personal psychotherapy than did female psychotherapists (73%) (Gilroy, Carroll, & Murra, 2001). Not surprisingly, studies showed that the non-therapy seekers did not see personal therapy as a valuable prerequisite to clinical work (e.g., Norcross, Bike, Evans & Schatz, 2008). They commonly reported either having no reason to seek therapy, or having sufficient coping strategies and effective ways of resolving personal difficulties (e.g., Gilroy et al., 2001). Amongst other reasons were concerns about confidentiality, credibility, fear of exposure, as well as cost and time constraints (Norcross & Guy, 2005). Further to this, those less likely to seek personal therapy were cognitive-behavioural therapists and academics, while psychoanalytically oriented clinicians had the highest prevalence of personal therapy (Norcross et al., 2008; Orlinsky et al., 2005).

Research indicates that amongst the most commonly cited reasons for therapists seeking therapy were personal distress and personal growth (e.g., Daw & Joseph, 2007; Macaskill & Macaskill, 1992; Norcross, Strausser-Kirtland, & Missar, 1988; Pope & Tabachnick, 1994; Rake & Paley, 2009; Rizq & Target, 2008, 2010a, 2010b). For example, a study conducted by Daw and Joseph identified two broad domains: personal impacts characterized by improving self-care and personal

development, and professional impacts consisting of experiential learning and learning from the client role. Similarly, Rizq and Target found that personal therapy for therapists was integral to training, providing an arena for intense self-experience and professional learning, facilitating establishment of self and other boundaries, and promoting self-reflexivity. Such self-reflexivity amplified therapists' ability to think about different aspects of themselves in relation to clients, a skill they recognized as essential to clinical practice.

While echoing previous findings, Rake and Pale (2009) also found that even negative experiences such as a therapist's dogmatic stance, or negative and too challenging remarks, were retrospectively recognized as helpful learnings of what to avoid in their own practice. Amongst other commonly cited improvements were the increased conviction that therapy can effect change, increased awareness of and sensitivity towards the client's needs and difficulties, increased capacity for empathy and genuineness, increased capacity to tolerate stress, and increased understanding of the importance of the therapeutic relationship (e.g., Grimmer & Tribe, 2001; Holzman, Searight & Hughes, 1996; Mackey, Mackey, & O'Brien, 1993; Macran & Shapiro, 1998; Macran et al., 1999; Strozier & Stacey, 2001). Participants also cited fewer professional difficulties and less burnout as long-term benefits of personal therapy (e.g., Wiseman & Egozi, 2006). However, research literature in the field of personal therapy for psychotherapists shows that there are serious problems inherent in this process. For example, Kirsner's (2000) study focuses on how a mandatory training therapy is experienced by candidates within psychoanalytic training. He alerts us to the problem of discrepancies in power within the therapeutic relationship and critiques organisational structures that mandate a training therapy. He holds the view that the status of such training is seriously compromised by its authoritarian and often indoctrinatory stance to which training analysts reluctantly submit themselves. Kernberg (2006) in line with Kirsner, provides a comprehensive evaluation of the problems of power imbalance inherent to the psychoanalytic training.

Far fewer studies have focused on the effect that a therapist's personal therapy has on specific psychotherapy processes and outcomes. Strupp (1973), in his seminal study, explored the influence the therapist's personal therapy had on the psychotherapy process. He measured the number of clinically appropriate responses to a series of client-therapist statements. Results indicated that therapists who had



been in personal therapy had a much higher number of clinically appropriate responses; for instance, they had fewer silent responses to schizoid material produced by severely disturbed patients. At the same time, experienced therapists who had not had personal therapy had more than three times the number of negative empathy ratings compared to those who had personal therapy. In a similar vein, Macran and Shapiro (1998) found therapists' who underwent personal therapy were more skilled in responding with interpretations to the transference communications from their clients.

Another study investigated the effects of a therapist's personal therapy on the therapeutic alliance (Gold & Hilsenroth, 2009). This study produced statistically significant differences on the therapist-rated alliance, in that therapists who had personal therapy compared to those who did not showed lower perceived rates of disagreement between tasks and goals of therapy, greater confidence in their own and the client's work, and greater commitment towards the therapy. Interestingly, while there were no statistically significant differences between the two groups on the client-rated alliance, there were significant differences in the number of therapy sessions attended by clients, with twice the length for the therapists who had received personal therapy. However, not all studies produced convincing evidence that a therapist's personal therapy has a significant effect on client outcome. For instance, Wheeler's (1991) study on therapists who worked with eating disorder patients showed a negative correlation between the amount of personal therapy of clinicians and the therapeutic alliance with clients.

Overall, while research on the benefits of personal therapy for a therapist's personal development appears conclusive, the findings on its relevance to treatment outcomes have generated conflicting evidence. In light of these inconclusive findings, some researchers have suggested the need for more studies to focus on therapy processes rather than patient outcomes (e.g., Macran & Shapiro, 1998, Orlinsky et al., 2005; Strupp, Butler, & Rosser, 1988). Therefore, further research determining the mechanisms or conditions under which personal therapy affects a therapist's practice is needed. In addition, studies on clients' experiences of therapy are typically limited to the clinical client population. The present study, therefore, aims to address these methodological limitations and obtain information vital to our understanding of how change is generated, manifested, and sustained by examining the client's subjective experiences from the perspective of both non-therapists and

therapists, with the purpose of eliminating the issue of selective sampling often found in these studies.

**Client-identified helpful and hindering factors.** In the same way as there is significant variability in treatment modalities and change facilitating techniques, there is huge diversity in terms of what clients consider helpful and hindering in facilitating therapeutic change. The existing studies on client-identified helpful and hindering factors fall into two broader categories: factors facilitative or obstructive to the therapeutic relationship and factors facilitative or obstructive to positive treatment outcomes (e.g., Booth, Cushway, Newnes, 1997; Elliott, 1985; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; Martin & Stelmaczonek, 1988). The overwhelming majority of studies focus on helpful rather than unhelpful factors (Timulak, 2010). This is surprising in light of existing data clearly indicating that exploring hindering factors is just as important in understanding mechanisms that generate change (e.g., Elliott; Greenberg, Rice, & Elliott, 1993). For the purpose of this review, findings on helpful and hindering factors will be presented in separate sections.

**Helpful factors.** In his pioneering research on helpful factors, Elliott (1985) organized them into two superclusters. The first cluster was task oriented and included new perspectives, problem solutions and clarification, and greater awareness. The second was an interpersonal supercluster that included factors such as client understanding, involvement, reassurance, and personal contact. Amongst helpful factors, the most commonly listed was development of new perspectives and understanding. Another group of the early studies also showed that clients perceived expressions of personal material, descriptions and explorations of feelings, insight and understanding, and developing new ways of being and behaving as helpful (e.g., Llewelyn et al., 1988; Martin & Stelmaczonek, 1988). Similarly, Hannah and Ritchie (1995) found clients rated insight or a new understanding as the most potent change-generating factor.

Elliott and James (1989) conducted the first major review of the literature on clients' experiences of helpful factors. They summarized them as falling into five categories: a) facilitative therapeutic characteristics; b) encouragement of client self-expression; c) supportive relationship; d) self-understanding and insight; and e) encouragement of extratherapeutic practice. The first three categories were understood as interpersonal aspects of therapy and the remaining two as task aspects

of therapy. The main limitation of this review was its reliance on data derived from indirect measures of client experience based on researchers' assumptions on what was helpful.

Alongside studies reviewed by Elliott and James (1989), other researchers began investigating helpful events in counselling. For example, Martin and Stelmaczek (1988) found that clients reported as helpful descriptions and explorations of feelings, moments that generate insight and understanding, and expressions of new ways of being and behaving. Helpful processes were also investigated in client-centred experiential therapy (Liatear, 1992). This study revealed three categories of helpful factors: i) relational climate of warmth and understanding, ii) therapists' interventions including confrontation and self-exploration, and iii) client related processes of insight and self-exploration. Similar findings were reported by Levitt and Piazza-Bonin (2011) who found that what was helpful in generating change were insight into self and new problem solutions, along with clients' positive interpersonal contact with the therapist (e.g., feeling supported or closer to the therapist).

In exploring the constituents of helpful therapeutic interventions, some studies concentrated specifically on therapist generated factors. One of the important studies in this area was conducted by Paulson, Truscott, and Stuart (1999). These authors attempted to minimize the influence of theory by involving clients in the process of data analysis. They also reported findings according to the relevance assigned by the clients. The most significant findings were centred around "therapist effects" and included the importance of the therapist's facilitative interpersonal style (e.g., supportive, empathic, open-minded, validating, followed my pace, allowed me to direct, gave me things to think about), therapist's skilful interventions (e.g., provided an objective opinion, facilitated my process, gave useful suggestions), and the ability to generate client resources (e.g., guided me step-by-step). Of particular value, from the client's perspective, was the generation of new perspectives and insights (e.g., new realizations about self and life), as well as enabling an environment conducive to client self-disclosures (e.g., unloading, sharing pain, feeling good for opening up) - all of which were consistent with previous research. Participants also identified factors less commonly reported in other studies, which included: emotional relief (e.g., emotional release, listening to self, and feeling realistic), therapist's accessibility (e.g., constant, once a week), and gaining

knowledge (e.g., linking what initially seemed unrelated) and obtaining resolution to their problems (e.g., problem solving, provision of tools, getting closure).

Another study, which concentrated on “therapist effects”, identified three distinct patterns of interaction between the client and the therapist leading to positive change (Wilcox-Matthew, Ottens, & Minor, 1997). The first was a “dissonant pattern”, in which the therapist challenged juxtaposed, questioned, or reframed clients’ descriptions of their problems. The second was a “question-answer pattern” in which the therapist offered interpretations and insights or suggestions and behavioural options that were perceived as accurate by clients. The third was a “congruent pattern” in which the therapist offered reinforcing and empathizing responses to the client’s complaint. These findings echoed previous research showing that a greater degree of change was linked to higher levels of therapists’ capacity to be affirming, understanding, and helpful (e.g., Elliott & Wexler, 1994; Henry, Schacht, & Strupp, 1990).

Levitt, Butler and Hill (2006) conducted a study investigating 26 participants’ reports of their experiences in therapy. Results were grouped into six clusters of which the largest was the therapeutic relationship. Of 26 participants, 21 described the relationship with the therapist as a central part of therapy. In terms of therapists’ qualities, 25 participants emphasized that acceptance, genuineness, attentiveness, and empathic concern facilitated their openness and progress in therapy (Levitt et al., 2006). Other researchers conducted a study investigating helpful and hindering aspects of therapy as perceived by clients who were in couples counselling (Bowman, Lee, Fine, & Marshall, 2000). Apart from listing the development of new understandings, all participants recognized a therapeutic atmosphere that generated trust in the therapist as an essential component of satisfying therapy.

Ribner and Knei-Paz (2002) completed a literature review, with a focus on finding what clients report as helpful in making their treatment successful. They noted that across a number of studies, there was a similarity in the results with respect to the therapeutic alliance. These elements of treatment that clients recognized as particularly helpful in generating positive treatment outcome included therapists’ positive regard, empathy, listening, understanding, support, encouragement, and acceptance.

Predominantly, studies on the client's perspective of change-promoting factors have been limited to short-term counselling. Studies that have focused on the client's experience of change in longer-term therapy are limited to client's experience of long-term health conditions (Bottomley, 1998; Lepore & Coyne, 2006; Robinson, Carroll, & Watson, 2005). They identified a range of factors that clients reported as helpful, including the therapeutic relationship, expressing emotions, telling the story, normalization, acquiring new coping skills, a structured approach to therapy, and exploring meaning and the possibility of death.

More recently, however, some attention has been focused on client-identified helpful factors in longer-term counselling. McLeod (2001) conducted an investigation on the constituents of effective interventions for clients experiencing long-term health conditions. He reported that clients found the quality of therapeutic relationship to be the central factor contributing to change. They typically enlisted a therapist's acceptance, understanding, and willingness to challenge as change facilitating. Further to this, clients perceived the length of counselling as an important factor responsible for positive change. Being given sufficient time made them feel as though they were being taken seriously, and that the complexity of their situation was being respected (McLeod, 2001). This, in turn, strengthened their relationship with the therapist. Further research into the change facilitating mechanisms in longer-term treatment will contribute new understandings of the therapeutic processes associated with positive outcomes of therapy with client groups other than those with long-term health conditions.

In order to understand what clients find helpful, some authors have suggested making a distinction between factors common across all types of treatments and those specific to different treatment modalities (e.g., Gershefski, Arnkoff, Glass & Elkin, 1996). Research indicates that, among non-specific factors, the therapeutic relationship was cited as helpful in all studies, and in some was explicitly correlated with the degree of reported change (e.g., Buckley, Karasu, Charles, 1981; Dimcovic, 2001). Therapists who had undergone personal therapy also valued the therapeutic relationship above therapeutic technique (Buckley et al., 1981). Irrespective of type of treatment received, clients also found helpful, gaining new information and acquiring new skills, receiving honest feedback, being given space for emotional expression, and self-disclosure (Clarke, Rees, & Hardy, 2004; Gershefski et al., 1996; Hsu, Crisp, & Callender, 1992; Llewelyn, Paulson, Truscott & Stuart, 1999).

Most studies have explored clients' experiences of therapy without considering the impact of specific treatment models (Ankuta & Ankuta, 1993; Dean, 1993; Dimcovic, 2001; Paulson et al., 1999). However, there are a handful of studies which have explored helpful factors linked to treatment specific interventions (Clarke et al., 2004; Gershki, Arnkoff, Glass, & Elkin, 1996; Llewelyn et al., 1988). Such comparative studies offer valuable data on how change processes operate in different types of treatment modalities.

Gershki and colleagues (1996) classified clients' responses into two broad categories: i) factors linked to a specific treatment model; and ii) common factors. They found that clients reported a higher number of helpful factors consistent with the model of therapy they had undergone. For example, clients in cognitive behavioural therapy (CBT) frequently reported exploration of thoughts, feelings, and behaviours as helpful, whereas clients who received interpersonal therapy conceptualized change in terms of relational awareness. Similar results were reported in a study that compared client perceptions of helpful and hindering events in two forms of psychotherapy: an exploratory, relationship-oriented therapy; and a prescriptive, cognitive-behavioural therapy (Llewelyn et al., 1988). Findings showed that clients in prescriptive treatment more frequently reported "problem solution" and "reassurance" as helpful, whereas clients in exploratory forms of therapy recognized "awareness" and "personal contact" as helpful.

Similarly, clients who experienced a cognitive analytic form of treatment found diagrams and letters to be particularly helpful interventions specific to this model (Bende & Crossley, 2000). These findings strongly indicate that client expectations are partially a function of the treatment model. These findings are not surprising given that other research has indicated that therapists do behave differently within different treatment models (Glass & Arnkoff, 2000; Heine, 1953; Clarke et al., 2004). Orlinsky and Howard (1986) have argued that clients achieved the 'therapeutic realizations' that are emphasized in the treatment model. However, it is difficult to determine the comparative influence of specific and non-specific factors. It is likely there is an interactive effect between specific and common factors within the context of client treatment expectations.

***Hindering factors.*** Studies on hindering factors are scant compared to explorations of factors that facilitate therapy (Bende & Crossley, 2000). Hindering

factors are rarely studied in their own right, but instead are part of comparative explorations of what clients find helpful and unhelpful in psychotherapy. It appears, however, that such research does not lend itself to a full explication of unhelpful experiences in therapy (Clarke, Rees & Hardy, 2004; Paulson et al., 1999). It may be that it is difficult for clients to recall negative aspects of therapy at the same time as they concentrate on helpful aspects. Consequently, existing inquiries into unhelpful aspects of therapy consistently reveal lists of factors that are simply the reversed helpful aspects (Bende & Crossley). Perhaps, not surprisingly, the most hindering factor was a negative and unempathic therapeutic relationship (e.g., Elliott, 1985; Henkelman & Paulson 2006; Hunt, Matthews, Milsom, & Lammel, 2006; Israel, Gorcheva, Burnes, & Walther, 2008). Similarly, one of the earliest enquiries into unhelpful events in therapy reflected clients' disappointment with the therapeutic relationship (Elliott, 1985). Specific factors included therapist misperception, negative reactions, repetition, misdirection, and unhelpful suggestions.

Studies that investigated hindering factors within specific treatment models found that unwanted thoughts, unwanted responsibility, and misdirection were reported with greater frequency by clients in exploratory, relationship-oriented therapy than in cognitive-behavioural therapy (Booth, Cushway, & Newness, 1997; Llewelyn et al., 1988). In comparison, clients' in cognitive behavioural therapy listed as unhelpful the pre-determined length of treatment, constrained number of sessions, and poor timing of termination, all of which were experienced as being entirely outside of their control. These findings suggest that at least some hindering factors are model-specific.

There are a series of studies on hindering aspects which indicate that unresolved misunderstandings between clients and therapists are particularly obstructive to positive change (Booth et al., 1997; Elliott, James, Reimscheussel, 1985; Greenberg, 1991; Llewelyn et al., 1988). In Levitt and Piazza-Bonin's (2011) study, the hindering impact of feeling misunderstood was further linked to experiencing no progress or solution to the problem. These studies reveal that misunderstandings typically originate either from the therapist's personal issues or the therapist's comments that are inconsistent with client's experience and sense of self.

Other investigations have examined the client's subjective perspective on resolved and unresolved misunderstandings (e.g., Rhodes, Hill, Thompson, &

Elliott, 1994). Resolutions were characterized by clients' perceived good therapeutic relationship, their willingness to assert negative feelings, and the therapist's ability to facilitate mutual repair efforts by maintaining flexibility and acceptance. Conversely, lack of a good therapeutic relationship, the therapists' inability to recognize clients' negative feelings, and therapists' unwillingness to accept or work through clients' negative feelings led to unresolved misunderstandings and premature termination of therapy. The results are derived from a cohort of experienced therapists and therapists-in training and therefore may not be generalizable to other clients, particularly those who exhibit more complex clinical presentations. In spite of that, these findings are in line with Safran's (1993) model of therapeutic ruptures and repair in which positive change occurs when the therapist is able to recognize clues that a rupture has occurred, and then facilitate the client's expression of negative feelings.

More recently, Israel et al. (2008) explored unhelpful therapy experiences of lesbian, gay, bisexual, and transgender (LGBT) individuals. They found that the most unhelpful for clients were situations where they felt judged, invalidated, or misunderstood by the therapist. Clients also identified a therapist's failure to create connection as particularly unhelpful. Equally unhelpful were interventions experienced as ineffective. These included 'why' questions, excessive self-disclosure, excessive use of silence, and withholding of feedback. Amongst harmful interventions were involuntary hospitalization, greater focus on assessment, diagnosis, and prescription of medication.

One of the most common consequences of the unhelpful situations (e.g., dissatisfaction, rejection, betrayal, frustration, and hopelessness) was negative impact on the relationship with the therapist. This typically led them to see the therapist as cold, disrespectful, disengaged, distant, or uncaring. As a result of unhelpful situations, clients ceased disclosing concerns, and developed more negative impressions of the therapist. Study conducted by Israel and colleagues (2008), showed that such events, while generating client negative reactions, often remain hidden from the therapist. There has been a series of studies confirming that clients' undisclosed negative reactions have negative consequences for progress in therapy (e.g., Hill, Thompson, & Corbett, 1992; Regan & Hill, 1992; Rennie, 1994; Rhodes et al., 1994).

It is clear that there is a consistency across studies in terms of what clients find



helpful and hindering in therapy. By and large, studies indicate that a good therapeutic relationship, along with the therapist's skills and interpersonal style, play a central role in generating therapeutic change. In addition, client change processes, such as gaining insight, developing new perspectives, finding new ways of addressing problems, and achieving emotional relief, were also commonly identified as helpful. By contrast, unhelpful events were mainly related to therapists' detached or unempathic stance, unhelpful interpretations or suggestions, and imposition of their own values and judgements. Clients' dissatisfaction with treatment is often aroused from feeling that their problems were either unrecognized or recognized but not altered in treatment. This was consistently associated with therapists' lack of awareness or failure to work adequately on misunderstandings (Grafanaki & Mcleod, 1999; Levy, Glass, Arnkoff, & Gershefski, 1996; Lietaer, 1992; Rhodes et al., 1994).

At the same time, findings from these studies do not always support a sharp distinction between helpful and hindering events, as the effect was often determined by the context and timing rather than its intrinsic quality. For example, clients found the therapist's use of metaphor helpful and hindering depending on the timing, way of communicating it, and how appropriate it was in a given context. Also, in some instances, helpful and hindering events merged into each other; for example, when a client reported a helpful insight which was misunderstood by the therapist, or when a client developed a new storyline that was followed by the therapist's pursuit of irrelevant topics.

Despite there being a growing scope of research concerning itself with client-identified helpful and hindering aspects of therapy, the researchers collectively stress the importance of further investigation into this domain, which they argue remains underrepresented in the therapy literature. They also point out that failure to conduct further assessments on what clients find helpful and hindering contributes to maintaining a long-standing power differential with therapists being ascribed authority over clients. However, the overarching argument for this type of research is that it expands our understanding of the mechanisms by which positive psychological change is either generated or inhibited.

**Client-identified significant moments.** Significant moments in therapy have been defined as episodes consisting of a problem state and where the immediate in-session outcome that has been deemed significantly helpful or hindering to the client

(Greenberg, 1986; Hill & Corbett, 1993). Research on client-identified significant moments can be grouped into two categories: 1) moments centred on contributions to the therapeutic relationship; and 2) moments centred on contributions to treatment outcomes. These broad categories encompass both positive and negative moments concerning the therapist or therapy. However, research on significant moments differs from research on helpful and hindering factors in that it focuses on particular distinct events and explores the processes involved in generating these moments.

Leading researchers have argued that the most productive or the most hindering therapeutic work occurs during “significant moments”: hence understanding these complex processes has the potential to inform therapeutic practice (e.g., Elliott, 2008; Grafanaki & McLeod, 1999; Timulak, 2007). The importance of studying these moments where change is most likely to be observable is further supported by findings showing low convergence between clients’ and therapists’ perceptions of significant events (Bloch & Reibstein, 1980; Cummings, Slemon, & Hallberg, 1993; Elliott, 1983; Helmeke & Sprenkle, 2000; Kivlighan & Arthur, 2000; Llewelyn et al., 1988; Martin & Stelmachzonek, 1988). For example, therapists typically perceived insight as significant, whereas clients placed more value on the relational aspects of therapy.

Significant events in psychotherapy have been investigated through identifying moments of therapeutically transformative effect. Originally developed by Elliott (1989), this ‘significant moment’ paradigm aimed to expose specific events or therapy processes responsible for change. These studies examined a broad spectrum of themes, predominantly centering on client-identified moments of insight (e.g., Elliott et al., 1994), moments of client deference in psychotherapy (Rennie, 1994; Watson & Rennie, 1994), moments of misunderstanding as viewed by clients and therapists (Rhodes et al., 1994), helpful and hindering moments (Elliott et al., 1985; Grafanaki & McLeod, 1999; Paulson et al., 1999), and change events (e.g., Wiseman & Rice, 1989).

Another line of study into significant moments focused on their therapeutic impact on the client (Elliott, 1985). Elliott defined therapeutic impact as the immediate effect on the client of a therapeutic intervention or session. These moments are also referred to as ‘therapeutic realizations’ or ‘micro-outcomes’ (Orlinsky & Howard, 1986). They further explain that therapeutic impact identifies and characterizes significant events and, in doing so, serves as an intermediate link

between process and outcome. This research paradigm is based on the premise that there is a correlation between significant events and treatment outcome (Timulak, 2007). However, there are only a small number of studies that have investigated this relationship and provided evidence for this link (Booth, Cushway, & Newness, 1997; Elliott, 1985; Llewelyn et al., 1988).

Timulak and Lietaer (2001) found that significant events centred on developing the therapeutic relationship or in-session changes were responsible for generating positive outcome. In a more recent study, Timulak, Belicova, and Miller (2010) explored client-identified significant events in successful therapy cases to establish whether therapeutic change was linked to helpful therapeutic events throughout the course of therapy. Analysis showed that significant events contributed to building the therapeutic relationship, as well as providing corrective interpersonal and emotional experiences. It also confirmed a link between the in-session impact of significant events and the overall outcome. Specifically, findings showed congruence between processes and helpful impacts reported in significant events and the resolution of problematic issues presented in therapy – that is, treatment outcomes.

Significant events have also been studied through identifying and exploring innovative moments in psychotherapy (e.g., Alves et al., 2014; Goncalves, Matos, & Santos, 2009; Goncalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Matos, Santos, Goncalves & Martins, 2009). Innovative moments are novel moments that are in sharp contrast to a client's problematic self-narrative. They develop out of therapeutic dialogue and have the potential to facilitate the construction of new meanings. The innovative moments research is grounded in the narrative framework, which posits that meaning develops through the narration of the self, others, and the world (e.g., McLeod & Angus, 2004; McAdams, 2001; Sarbin, 2005). There is a focus on 'unique outcomes' which are exceptions within a problematic self-narrative (White & Epston, 1990).

There appear to be five different types of innovative moments: i) action: behaviours that counter the problem or are incongruent with problematic pattern; ii) reflection: thinking processes indicating understanding of something new that creates a change in the problematic pattern; iii) protest: moments of critique containing some form of confrontation directed at self or others; iv) reconceptualization: development of a meta-reflection level of understanding of what is new and

different, as well as the process of transformation; and v) performing change: anticipation or planning of new experiences on personal, professional, and relational levels.

Analysis of therapy sessions in good and poor outcome cases showed that innovative moments were present in both instances; however, in a good outcome group participants spent significantly more time elaborating on these moments (Matos & Santos, 2009). The good outcome and poor outcome groups did not differ in action, reflection, and protest categories; however, significant differences were found in reconceptualization and performing change. Poor-outcome cases had almost no moments related to reconceptualization or performing change, whereas good-outcome cases had a significantly higher elaboration of all types of innovative moments. Here, action, reflection, and protest were considered the most elementary forms of innovation, and whilst being necessary they were not sufficient for the development of a sustainable new self-narrative. It is the stage of reconceptualization and performing change that appeared crucial for the construction of a new self-narrative. In those later stages clients were able to integrate past with present, assume authorship, and give meaning and order to earlier episodic innovations of action, reflection, and protest. These findings were replicated in several other studies (Goncalves et al., 2010; Matos et al., 2009).

Another line of research concerned with processes occurring across client-identified helpful or unhelpful significant moments were Grafanaki and McLeod's (1999) exploration of narrative processes. Here, clients gave high helpfulness ratings to instances when they felt their therapist understood their story; the converse was true when they experienced their therapist as inattentive and failing to appreciate the meaning of their narrative. These authors argued that it was the pervasiveness of the presence of the therapist as audience that made the client's experience of 'telling-to-another' helpful. For example, the therapist's empathic witnessing of client pain led to a diffusion of shame; this then enabled the client to successfully recount the full 'shameful' story, leading to relief and a sense of achievement. Conversely, if the therapist was perceived as a detached and shame-inducing audience, clients experienced their own disclosures as premature and therefore unhelpful. During this process of recounting their life narrative, clients often became aware of new aspects and experienced new emotions, and entered an area of new feeling (employment of emotion) and developed a new, more

empowering, and emancipating story line. By contrast, clients found it hindered their process when the therapist initiated the new story line; they regarded this as untimely, intrusive, and threatening. However, when the therapist was able to notice and communicate to the client the first emergence of a new way of reconstructing the life narrative, this was experienced as helpful. This study, while employing qualitative and quantitative methods of investigation to increase the validity of the conclusions, nevertheless relied on a very small sample (6 participants) who received a time-limited (12 sessions) experiential (person-centered) form of therapy. This raises the question of whether similar findings would be observed across other therapeutic orientations which utilize different narrative change strategies.

Helpful and hindering significant moments also affected the quality of the client-therapist relationship. There was a rhythm in the interaction between client and therapist that was characterized by 'achieved flow' when the process was productive, or 'interrupted flow' when the process was hindered (Grafanaki & McLeod, 1999, 2002). During helpful experiences there was a sense of 'achieved flow' (which are experienced by clients as highly affirming, life-enhancing, and memorable moments) between the therapist and client that facilitated the process of storytelling, a characteristic that was absent during hindering moments. There was a quality of dyadic interaction with shared, mutual engagement from which both were able to contribute to the telling of the story (Grafanaki & McLeod, 2002). Grafanaki and McLeod found that, at times of 'achieved flow', a new story line emerged in the presence of an affirming therapeutic presence. Times of 'interrupted flow' represented rupture and were characterized by a confused or stuck story line experienced in the presence of a detached, critical, or uncomprehending therapist.

Research shows that client-identified significant moments are of high therapeutic value. However, processes underlying significant moments are not fully understood in their complexity (Timulak, 2010), particularly given that the client perspective on the nature and significance of these moments often differs dramatically from that of the therapist. For instance, it has been well established that clients, unlike therapists, value emotional and relational over cognitive aspects of significant moments. Further to this, studies show that significant events are deeply contextually embedded and non-linear, in that they often contain both helpful and hindering components (Grafanaki & McLeod, 2002).

Studies on the clients' experiences of significant moments explore either broad aspects or very specific events in therapy. There are two types of limitations, therefore, inherent in these studies: they either enable only very general or out of context exploration of the studied phenomenon, resulting in a superficial summary of various significant events, or in-depth ones, but without relationship to the context of the whole therapy process (Timulak, 2010). In the same vein, Timulak and Elliott (2003) argued that findings from significant event studies are frequently reported and discussed without being sufficiently situated within the larger context of the therapy process. Typically studied events are also pre-selected and sampled from different clients and different sessions, most likely leading to the exclusion of certain types of events. Some studies, while examining a broader spectrum of client-identified significant events are frequently limited to brief therapy (e.g., 3-4 sessions), and this often prevents seeing patterns of change (Cummings, Barak & Hallberg, 1995; Timulak & Lietaer, 2001). While there are most likely other forms of significant events that are yet to be reported in the literature, it is important to continue exploratory qualitative research in this domain with the aim of delineating the different types of processes that generate significant events within psychotherapy.

**Client agency and expectancy.** Common factors research places the client's personal resources, including agency, drive, and determination, amongst the most potent forces responsible for change (e.g., Dreier, 2008; Bohart & Tallman, 1999; Makrill, 2008; Rennie, 1994). Similarly, research has produced ample empirical evidence that client expectancy plays an important role in accounting for a positive treatment response (e.g., Dew & Bickman, 2006; Greenberg, Constantino, & Bruce, 2006; Lambert, 1992; Zuber, 2000). It has been widely accepted by researchers, theorists, and clinicians that clients bring to therapy particular sets of beliefs, expectations, ideas, and hopes, which influence the subsequent experience of the therapy process and outcome.

In spite of the overwhelming evidence and general consensus that client agency and expectancy are central to the therapy process and outcome, they are amongst the least researched factors (Baillie & Corrie, 1996; Kuhnlein, 1999; Levitt & Rennie, 2004; Nock & Kazdin, 2001; Westra, Aviram, Barnes & Angus, 2010). As pointed out by Elliott (2008), one of the most important developments in client experience research is the emergence of studies showing clients to be active agents of change. However, he stresses the need to continue exploring how clients use

therapy to change themselves. This is based on the premise that these processes, if unknown to the therapist, become inaccessible for therapeutic utilization and modification.

Researchers, who perceive the client as a primary agent of change have argued that different approaches to therapy work equally well because of the self-healing capacity of the client (Bohart & Tallma, 1999; Duncan et al., 2010). In keeping with this perspective, Prochaska, DiClemente, and Norcross (1992) stated that: “all change is self-change and therapy is simply professionally coached self-change” (p. 17). These self-healing and agential qualities, which transcend any specific school of therapy, have been reflected in Dreier’s (2008) study showing the client to be the main agent of change process. This research showed that: (a) the client uses psychotherapy sessions in highly selective ways and chooses particular parts or aspects of it in addressing problems; (b) the client processes those selected topics outside of therapy, and modifies, changes, and reinterprets them; (c) interpretations and use of psychotherapy sessions differs widely among the clients in the same case and different events are significant for different clients; and (d) psychotherapy has different individual meanings, predominantly because psychotherapy deals with highly subjective matters (Dreier, 1991, 1998, 2008). This perspective is in line with earlier findings showing clients to be highly active recipients of treatment with their own agendas, expectations, and hopes that undergo an ongoing evaluation (Elliott & James, 1989).

Rennie’s (1994, 2000, 2001) pioneering studies showed clients to exert control over the relationship with the self, the therapist, and the therapist’s technique. Clients were agential in influencing the therapist’s perception of them, and seizing control over raised issues. They were also interested in, and actively contributed to, establishment, maintenance, or repair of the working alliance and took on the following roles: sole agents dealing with their experiences, collaborating with the therapist, combating the therapist’s agency, or acquiescing to the therapist’s agency (Rennie, 1994). Highlighted here is the client’s capacity to be covertly agential by saying one thing while thinking another, and by paying selective attention to therapists’ suggestions. It is noteworthy however, that the subjects in Rennie’s enquiry were all middle-class and highly educated and therefore could have a higher capacity for reflexivity and critical evaluation of their interactions with their therapists. Similarly, William and Levitt (2008) found that clients were preserving

the relationship with the therapist, through seeking to create a safe atmosphere, by actively minimizing the differences and focusing on factors that supported the relationship. Clients also avoided talking about differences if they thought this to be out of the therapists' control or potentially threatening to the therapeutic alliance.

Research on how clients deal with difficulties showed that they construct a mental image of the therapist (an internal representation) to continue therapeutic work between the session and after therapy is over (Knox, Goldberg, Woodhouse, & Hill, 1999). This is a unique finding indicating clients' positive ways of using therapy in order to overcome obstacles to change. It is important to notice that these findings derived from a particular treatment modality with strong psychodynamic leanings and therefore do not provide any insight as to how and if clients in other forms of treatment experience internal representations. In addition, other studies indicate change processes to be cross-contextual, in that clients pursued change in all contexts of their life, therapy being only one of them (Dreier, 2008; Gold, 2000; Mackrill, 2007, 2009). Thus, client agency does not exist independently of therapy, for the client pursues change across contexts and is an agent everywhere by utilizing multiple avenues and arriving at new interpretations or evaluations of their problems (Dreier, 2008; Mackrill, 2009). It is of significance, however, that the findings provided by Dreier and Mackrill are derived from single case studies and as such, only allow for tentative generalizations.

Research has also shown that client expectancy plays a central role in generating positive treatment outcome, in that the more positive the expectations held by clients the greater reported improvements (e.g., Dew & Bickman, 2005). Specifically, research indicates that clients' expectations regarding the therapist and therapy play a significant role in determining treatment outcome (e.g., Arnkoff, Glass, & Shapiro, 2002; Greenberg, Constantino, & Bruce, 2006; Westra, Aviram, Barnes & Angus, 2010). For instance, research evaluating client accounts of initial expectations and subsequent experiences in therapy found that positive surprise and disconfirmation of initial negative expectations were associated with positive outcome, whereas disappointment and disconfirmation of positive expectations lead to negative outcome (Westra et al., 2010). In short, there is a substantial amount of research linking poorer psychotherapy process and outcome along with higher dropout rates with client disconfirmed expectations for psychotherapy (Baekeland & Lundwall, 1975; Garcia & Weisz, 2002; Hansen,



Hoogduin, Schaap, & de Hann, 1992; Nock & Kazdin, 2001; Reis & Brown, 1999; Walitzer, Dermen, & Conners, 2002; Webb & Lamb, 1975; Ziemelis, 1974).

Clients' pre-existing beliefs about the problem formation and resolution significantly influence their acceptance or rejection of a particular form of treatment (e.g., Elkin, 1999, Witt & Elliott, 1985; Wampold, 2006). Attribution research suggests that it is the level of congruence between the therapist and client theories of problem formation and resolution that determine treatment outcomes (Atkinson, Worthington, Dan, & Good, 1991; Bohart, 2000; Claiborn, Ward, & Strong, 1981; Duncan & Miller, 2000; Warthington & Atkinson, 1996). This was reflected in research findings showing that clients benefited from explanations provided by their therapists, the more they were in line with clients' internal experiences (Angus & Rennie, 1989). Given these findings, a growing number of researchers argue that therapy should be conducted within the client's frame of reference and with emphasis on their theory of change (Bohart, 2000; Gold, 2000; Held, 1991; Hubble et al., 1999; Mackrill, 2008). Furthermore, in light of studies that consistently show therapists to be ineffective at predicting client deterioration or treatment drop out, it seems even more important to consider clients' theories of problem formation and resolution in treatment planning and delivery.

The convergence between client and therapist perspectives has been shown to directly relate to the strength of therapeutic alliance, session effectiveness, and positive outcome (Cummings et al., 1992; Kivlighan & Arthur, 2000). This is of a particular concern, in light of research findings showing high divergence in therapists' and clients' views regarding psychotherapy process (Angus & Rennie, 1988; Elliott & James, 1989; Elliott & Shapiro, 1992; Heppner, Kivlighan, & Wampold, 1999; Levitt & Rennie, 2004; Martin & Stelmachzonek, 1988). These discrepancies in judgment are further reflected in the therapeutic alliance findings, consistently showing either small correlations or stable lack of convergence for therapist-client alliance ratings (Fitzpatrick, Iwakabe, & Stalikas, 2005; Mallinckrodt & Nelson, 1991). In addition, studies on the client-therapist dyad perceptions of unspoken concerns revealed that, in the majority of instances, clients and therapists did not tell one another when such moments occurred (Heppner, Rosenberg, & Hedgespeth, 1992; Moreover, Levitt & Piazza-Bonin, 2011). At the same time, researchers found that, if directly questioned, clients tend to reveal intentions, purposes, and motives typically not mentioned to their therapists (Levitt

& Rennie, 2004).

In light of these data, it is surprising that only a limited number of studies attempted to explore clients' intentions, motives, and ways in which they exert control and utilize internal and external resources in therapy. To date, there has been no comprehensive qualitative inquiry into the role clients' theories of problem formation and resolution play in generating psychological change. Given this relative research neglect and the particular significance of client agency and expectancy factors in generating positive treatment outcome, it is of great importance to continue exploring the role clients' beliefs and expectations play in therapy. It is argued here that these explorations into clients' intentionality and formulations are indispensable to our understanding of interpersonal processes that influence effective psychotherapy. More direct enquiries are necessitated by the data indicating frequent absence of explicit communication between the therapist and client regarding processes generated during therapy sessions.

### **Change in Psychotherapy: Review of Selected Models**

Theories and models of change provide organized frameworks and conceptual order to our observations about human behaviour. Theories comprise integrated sets of statements that describe, explain, and predict behaviours. They present a matrix of concepts that can be subsequently linked to measured constructs. Models that derive from theoretical constructs allow for empirical verification of these theoretical predictions, therefore providing sound basis for practical applications. Despite the proliferation of theories and models there is no consensus about the course of change clients follow during therapy. Some theorists perceive change as a unitary process common to all clients (e.g., Goldfried; Prochaska & DiClemente, 1982), while others argue alternative course of change in different clients or in the different problems clients bring to treatment (e.g., Cummings et al., 1994; Elliott, 1983; Hill & Corbett, 1993; Stiles & Shapiro, 1994). This section will focus on discussing and critically evaluating the most extensively utilized models of change.

**Models of change.** Studies that focus on specific mechanisms of the change process employ various theoretical models of change. There are cyclical models of change that based themselves on the process of interaction and recursion. They include: the *Referential Cycle Model* (Bucci, 1993), *The State of Mind Model*

(Horowitz, 1991) and the *Therapeutic Cycle Model* (Mergenthaler, 1996). Amongst other commonly utilized models are those focusing on self-narrative reconstruction, such as the *Heuristic Model of Therapeutic Change* developed by Goncalves, Matos, and Santos (2009) and Angus and Greenberg's (2011) *Dialectical-Constructivist Model of Change*. However, the most extensively cited models of change are: *The Transtheoretical Model of Change* (Prochaska & DiClemente, 1982), and *The Assimilation of Problematic Experience Model* (Stiles et. al., 1990) and it is these latter two that are summarized below.

***The transtheoretical model of change.*** Prochaska and DiClemente's (1982) Transtheoretical Model of Change is a comprehensive behavioural theory, which aims to explain how people change during and between therapy sessions. This model represents an integrative approach to change, with the main aim being to "accommodate, through its systemic and comprehensive flexibility, the endless varieties of clients, problems, and therapists" (Held, 1991, p. 207). In other words, this model aims to determine the principles of change common to all theoretical orientations. In doing so, Prochaska and DiClemente (1984) distinguished between the process and content of change and defined process as representing "a middle level of abstraction between a complete theory or system of psychotherapy and the techniques proposed by the theory" (p. 33). This definition implies that the theory of how people change in and outside of therapy should provide general clinical strategies to promote change. They further argued that therapeutic approaches vary to the greater extent in *what* needs to be changed than how to promote change. They conducted a comparative analysis of leading systems of psychotherapy and distinguished five fundamental processes of change - consciousness raising; catharsis; choosing; contingency control; and conditional stimuli. These five processes were used to develop the stages of the Transtheoretical Model of Change.

The Transtheoretical Model assumes that change typically involves progression through a sequence of six specific stages, namely precontemplation, contemplation, preparation, action, maintenance, and termination, where each stage represents "a period of time and a set of tasks needed for movement to the next stage" (Prochaska & DiClemente, 1984, p. 149). Precontemplation is characterized by a lack of intention to change and is typically associated with lack of awareness of the consequences of the behaviour or some level of demoralization, resulting from previous unsuccessful attempts to change. In the next stage, people began

contemplating change and show more awareness of pros and cons of changing. This stage of contemplation is followed by the preparation stage in which people intend to take action in the immediate future and have a plan for addressing the problem. The next stage is described as an action stage. Here, people make specific modifications in their lifestyle. This stage typically involves behavioural change. The following stage focuses on maintaining those gains and working to prevent relapse. This is followed by termination, which is the final stage and is characterized by full self-efficacy.

Prochaska and DiClemente acknowledge that at any time during the progression through these stages, an individual can relapse into a previous stage of behaviour. Individuals attempting to make changes typically go through a cyclical process of progressing and relapsing (Norcross, Krebs, & Prochaska, 2011; Prochaska, 1995). They argue that, the change processes associated with cognitive, experiential and psychoanalytic persuasions are most useful in the early stages of precontemplation and contemplation, whereas the existential and behavioural approaches best match the stages of action and maintenance. On the basis of these findings, they propose that the therapist's relational stance should be aligned with the nature of each stage. That is, in the precontemplation stage, the therapist's role resembles that of a "nurturing parent" supporting the client through the conflicting process of wanting to change and resisting it (Norcross et al., 2011). In the contemplation stage, the therapist needs to assume the role of a "Socratic teacher" promoting development of client's own insights into their condition. The preparation stage requires skills of an "experienced coach", whereas action and maintenance are best addressed by a stance of "consultancy" with its availability of support and advice when needed. In the termination stage the client's autonomy is well established and there is less need for the therapist to exercise the role of a "consultant" (Norcross et al., 2011).

This model, originally developed to understand changes in health behaviours, has been most extensively researched and applied within the psychological treatment of wide array of behaviour problems (Prochaska & Diclemente, 1984, 1986, 1992). As discussed above, according to this model, behavioural change occurs in a series of discrete stages. While stages of change refer to the sequence of changes, the process of change describes what the overt and covert activities that clients engage in to modify problematic behaviours (Prochaska & Norcross, 2010). Research

indicates that there is a common set of change processes that can be identified across diverse disorders (Prochaska, DiClemente & Velicer, Gimpil, Norcross, 1985).

Although this model has been commonly used to guide psychological interventions, some research suggests that the proposed stages are not mutually exclusive and that there is no compelling evidence of change occurring in the sequential movement through discrete stages (Carey, Purnine, Maisto, Carey & Barnes, 1999; Littell & Girvin, 2002; Weinstein, Rothman & Sutton, 1998). The model has been criticised for its oversimplification of the complexities of the nature of change with its imposition of artificial categories on continuous processes (Davidson, 1998; Little & Girvin; Sutton, 1996). This has led to a division amongst researchers as to whether change is best represented as a continuous process or by discrete stages (Prochaska & DiClemente, 1998).

Despite extensive research, the question as to how and why change occurs is still largely unanswered (Fraser & Solovey, 2007). The Transtheoretical model, whilst providing a clear description of the change process delineated through stages, does not simultaneously provide an explanation of how change occurs, nor does it provide a unitary framework for the findings from subsequent studies (Sutton, 2001). According to Mansell (2005), the recent movement towards transdiagnostic theories and treatment approaches indicates that common processes underlie the causes, maintenance, as well as relief from different forms of psychopathology. They further argue that exploring the nature of change from a transdiagnostic perspective validates the search for common underlying patterns of change within various psychological presentations and treatment approaches.

In summary, the transtheoretical model proposes that change result from sequential progression through each of these five stages. However, research suggests that while change has an intentional dimension that is reflected through a stage like progression, it also consists of a non-linear dimension which cannot be discerned purely based on meeting observable goals. Thus, change is a dynamic concept, which reflects a number of underlying constructs, of which stage-like models addresses only one aspect.

***The assimilation of problematic experience model.*** The second theoretical model commonly employed to study processes of change is The Assimilation of Problematic Experience Model (Stiles et al., 1990). This is a cyclical model characterized by the process of interaction and recursion. This model draws on

conceptual and empirical work by Piaget and Rogers, defining a systematic sequence of change during therapy. The model proposes that problematic experience is gradually assimilated into a schema that is developed during the therapist-client interaction. A schema is a familiar pattern of ideas, to which new experiences can become assimilated (Stiles et al., 1990). The central change mechanism is the process of assimilating experiences that have become incongruent and problematic, and no longer can be sufficiently contained by available cognitive structures. According to these researchers, the assimilation of problematic experience is a common change mechanism, a component of most psychotherapy models.

The assimilation model suggests that the client progresses through common stages in overcoming problems as they are processed and assimilated into schemas developed throughout the therapy. There are 4 stages: i) unassimilated experiences, ii) partially assimilated experiences, iii) the assimilated stage, and iv) the applied stage. The model proposes that there is a parallel sequence of emotional reactions as the client passes through these stages. These include: being oblivious and uncaring, experiencing the content as painful, then as problematic but less distressing, then as puzzling, then as understood, and finally as confidently mastered (Stiles et al., 1991).

According to this model, some events within therapy result in sudden increases in assimilation. These events typically trigger strong affective reactions and are associated with distinctive immediate therapeutic impacts (Stiles et al., 1990). Such therapeutic impacts have been identified on a taxonomy derived from the client descriptions of helpful and unhelpful factors in therapy (Elliot, 1985). These impacts are experienced by the client in relation to the stages of the assimilation continuum. In the unassimilated stage the client experiences unwanted thoughts and rates this impact as unhelpful, due to the increased psychological pain. In the next stage, the client experiences awareness, which reflects movement from poorly articulated experiences to an awareness of one's feelings. In this stage the client has greater ability to put the experiences into words. The next impact is described as problem-clarification and reflects movement from an uncomfortable awareness of the problem to the development of an idea of what needs to be changed. In this stage the client is able to clearly describe the problem(s), task(s), and goal(s). This is followed by personal insight, where the client's descriptions reveal something new about the self, seeing new connections about the self, and the self in relationship to others. This reflects comprehension of experiences in terms of

new schemas developed in therapy. The last phase is the problem solution impact. At this point the client typically describes a specific plan of action, which reflects application of the assimilated material and an ability to extend this into daily life.

### **Summary and Conclusions**

The research trends over the past two decades have underscored the importance of the client's lived experience of psychological change. A growing number of researchers have criticized the existing literature for its limited focus on the client's subjective experience of change in psychotherapy (Bohart & Tallman, 1999; Duncan & Miller, 2000; McLeod, 2012). It is also clear from research findings discussed in this chapter (e.g., Bohart, 2000; Duncan et al., 2011; Lambert & Barley, 2002) that investigating the client's ways of utilizing psychotherapy is essential to developing more accurate theories and techniques for successful implementations into psychotherapeutic interventions. It is therefore important, from both an academic and clinical perspective, to generate more data on the client's understanding of factors responsible for promoting and sustaining therapeutic change (Bohart & Tallman, 1999; Duncan & Miller, 2000; Gold, 2000; Howe, 1993; Manthei, 2007; Timulak & Elliott, 2003). Therefore, the overarching aim of this study is to complement existing research by providing a comprehensive in-depth analysis of the client's experience of therapy. In line with this assertion, the core research question of the present study is: *How does therapeutic change occur from the client's perspective and what factors account for that change?*

The significance of this study lies in its efforts to explore the client's insight into the process of therapeutic change, thereby directly contributing to the knowledge informing effective therapy practice. Of major importance for this type of research is the substantial amount of data showing significant divergence in client and therapist perspectives on factors facilitating psychotherapy (e.g., Howe, 1993, Manthei, 2007; McLeod, 2001), and reinforced by a succession of studies indicating a high level of client agency in the therapeutic process (e.g., Dreier, 1998, 2008; Kuhnlein, 1999; Makrill, 2007, 2008; Rennie, 1994, 2000, 2001). In the light of these findings, it seems important to give voice to clients when attempting to better understand what accounts for positive change in therapy. This will be attained through a qualitative exploration of the client's post-therapy recall of their experience of change in a medium-to longer-term therapy.

Whilst it might be important to identify model specific change generating factors, research is pointing towards greater significance at identifying factors common to all types of therapies. Specifically research indicated the effectiveness of psychotherapy as being attributed to pantheoretical factors, amongst which the client is the most potent source of therapeutic change (Duncan et al., 2010). Above all, therapy is a highly subjective process which, when interpreted in line with specific theoretical models, is likely to constrain clients' accounts and reveal a limited understanding of the processes involved. This study therefore will refrain from distinguishing treatment-specific factors and focus on exploring factors common to change across different treatment modalities.

The impetus for this research also lies in the recent emphasis on accountability in health care, leading to increased 'empirical validation' of psychotherapy treatments. These validations, however, rarely include client views on factors contributing to the effectiveness of therapy. A literature review instead revealed that the discourse on what makes therapy work, while largely focusing on empirically validating treatment modalities, has been predominantly reliant on the therapist's understanding of what constitutes a successful therapeutic intervention. In response, Wampold (2006), in response stressed that insurance companies fund only a limited number of 'empirically validated' treatments and therefore consumer and provider choices of services being offered will largely diminish. Thus, it seems particularly important to allow the consumer to have a voice in influencing what kinds of treatment they will be entitled to. Factoring client views into the way therapy is delivered has the potential to increase customer satisfaction and successful treatment outcomes (Duncan et al., 2010; Manthei, 2007). This study will respond to these issues by exploring change from the broader consumer perspective as experienced by psychotherapy clients. It is hoped that these qualitative research findings will generate hypotheses which can be quantitatively tested and in turn, provide empirically validated findings that also consider consumer choices.

This literature review has shown that researchers, theorists, and clinicians have a vested interest in understanding the nature of clients' experiences in psychotherapy. This striving for understanding exists regardless of specific schools of therapy, presenting problems or diagnosis, and the context of treatment. However, there has been little progress in reducing the tendency for research design and analysis to be theory driven. There still needs to be a greater attempt at research



enabling clients to give voice to what they consider to be important, in a way they feel is relevant to them. Relying upon inferences or reports of clients' experiences in therapy is necessary to enable a shift from "an idiographic approach useful for the particular client to a general approach where the information is useful for practitioners and researchers" (Roussos, 2013, p. 504). The present study aims to address these methodological limitations and obtain information vital to our understanding of how change is generated, manifested, and sustained by conducting comprehensive multi-dimensional explorations of clients' experiences of therapy.

The current study differs from previous research in a number of ways. As already discussed in this section, the existing studies, on the client's experience of therapeutic change, have only selectively focused on either exploring general perceptions of helpful and hindering factors or examining pre-determined significant moments assumed to be associated with change. This study, on the other hand, aims to provide a comprehensive exploration of processes that lead to change in psychotherapy. The research design was therefore developed to explore the content and process of change as experienced by the client. It comprises five domains, which have been previously researched individually and independently of one another, including: perception of change, stages of change, helpful and hindering factors, significant moments, and client agency.

In addition, one new area has been added which has not been previously investigated: problem formation and problem resolution. This study, then, builds on previous research through the addition of a new domain, and a comprehensive analysis of all previously research domains with two client groups, therapists and non-therapists. It is anticipated that this comprehensive and comparative study of client experience of change in psychotherapy will extend current knowledge and potentially form the basis for a client-centered model of change. Furthermore, in order to establish parameters for a comprehensive conceptualization of therapeutic change, two of the most extensively tested models of change will be utilized. It is assumed that these models provide a sufficient platform to guide initial conceptualization of clinical findings in the current study.

Examination of client experience also advances our theoretical understanding of the processes mediating change within the session, as well as post-session and post-treatment change, which in turn may enable a more accurate prediction of treatment outcome. In addition, understanding different forms of the client

experiences can lead to more effective interventions ‘catered’ for particular clients. Specifically, therapists across all therapeutic schools rely upon inferences or reports about a client’s current experience in order to determine selection and modification of therapeutic interventions.

Given these considerations, it is of paramount importance to determine what knowledge can be derived from systematic explorations of client experience in therapy. In particular, this could bring researchers and clinicians closer to understanding the nature of therapy, and the main domains and underlying dynamics of clients’ therapeutic experience. It is therefore hoped that by considering all of these dimensions, it will be possible to build up a comprehensive picture of the ways different factors interact in therapy, leading to long-lasting changes and, in doing so, contribute to the development of applied clinical knowledge.

It is also hoped that some insight will be gained as to how these changes can inform therapists’ clinical practice. In general, there is a great need to continue to build on the existing evidence base and provide updated research, as there is a growing demand from various stakeholders to show that psychotherapy effects psychological change. In conclusion, following Stiles’ (2013, p. 39) recent contention that a “solid empirically supported theoretical account of how people change and how psychotherapy facilitates changes is such a pressing prerequisite”, this research aims to participate in contributing to this knowledge base, by showing what change is like for clients examining what meaning and importance they ascribe to it.

The existing research, detailing client contributions to change, strongly supports the notion of factoring the client’s views into the way theory is developed and treatment is conducted. It is argued that client views on the nature of change in therapy are among the under-researched and underrepresented domains in the field of psychotherapy research (Elliott, 2008). This study, therefore, aims to discover specific factors facilitating therapeutic change elicited from client accounts of therapy. A structure for investigating client theory of change was conceptualized based on the existing research and theory on the client’s experience of therapeutic change. The possible implications for understanding the change process from the client’s perspective include the following:

1. Findings from this study may offer implications for therapy practice in that they could increase therapists’ ability to become more change focused. The

themes that emerge from the data could assist therapists in gaining a better understanding as to the nature of the client's experience of change. Elliott and James (1989) refer to this as 'sensitizing categories' that can facilitate therapists' choices in selecting appropriate interventions for a given client.

2. The information emerging from qualitative exploratory research on the client's perception and experience of the nature of change may offer a contribution to creating a more concrete basis for measuring important elements of change in the therapy experience. This knowledge can provide a basis for developing psychometric measures of the client's experience of change, and the nature of change processes in therapy.
3. The far-reaching significance of this study may influence the way therapy is conducted. For example, there could be implications for an exchange from theory-driven 'objective truths' to incorporating clients' 'points of view' in promoting their therapeutic change.

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## **CHAPTER Two**

### **Methodology**

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Investigating the client's understanding of change derives from a significant

body of research which indicates that the client is the single, most potent agent responsible for a successful outcome in therapy (e.g., Assay & Lambert, 1999; Lambert, 2013; Bohart, 2000; Dunca, Miller, Wampold, & Hubble, 2011; Norcross & Lambert, 2011). However, research on the mechanisms by which treatment leads to change, particularly as viewed by the client, is amongst the under-investigated and underrepresented domains in the psychotherapy field (Elliott, 2008; Greenberg, 2007; Howe, 1993; Kazdin, 2005; Manthei, 2007; McLeod, 2001).

### **Research Aims and Objectives**

The broad aim of the study to discover specific factors that catalyse and facilitate therapeutic change as perceived by the clients. The core research question in this study is: *How does therapeutic change occur from the client's perspective and what factors account for that change?* In addition, this study aims to explore the subjective experiences, feelings, and beliefs of individuals who have completed long-term therapy in relation to the process of change in psychotherapy. The specific objectives underlying this research are:

1. To explore client views on the factors that facilitate change in therapy;
2. To examine client perspectives on the therapist's role in bringing about therapeutic change;
3. To examine client perspectives on their own contributions to therapeutic change;
4. To investigate clients' informal theories of problem formation and problem resolution and to gauge their significance in facilitating therapeutic change;
5. To articulate a therapeutic change model based on client discourses on the nature of change.

### **Methodology: The Interpretative Paradigm**

This study utilized Interpretative Phenomenological Analysis (IPA) as the primary methodological approach. IPA is an inductive approach that sets out to explore how participants bring meaning to their lived experiences (Reid, Flowers, & Larkin, 2005; Smith, 2004). As argued elsewhere, representation of the clients' subjective experience of the psychotherapy process is very limited in psychotherapy research (e.g., Elliott, 2008; Greenberg, 2007; Manthei, 2007; McLeod, 2001). Macran, Ross, Hardy, and Shapiro (1999) provide the following rationale for employing interpretative epistemology to this type of exploratory investigation:

Phenomenologically, it is meaningless to attempt to be objective about something

which by its nature is subjective. If therapy has no meaning other than that attributed to it by its participants, then it can only be explained and analysed by reference to individual actions, thoughts and intentions. Clients are the most direct source of this information. We cannot fully know about clients' experiences, and therefore fully understand how psychotherapy facilitates change, without asking them. (p. 330)

The main focus of this research design was to explore clients' subjective experiences and interpretations of the process of change in psychotherapy. A qualitative approach within the interpretative tradition is in line with this aim, as its primary concern is the subjective understanding and experience of the individual in the area under investigation. In this methodology, participants are assumed to be the experts on their own experiences. They provide the researcher with insight into their thoughts and feelings, via the facilitation of a relatively unobtrusive narrative process. The interpretative approach affords the researcher an opportunity to discover the *quality* that is essential to the nature of investigated phenomenon.

There is a range of research methods appropriate for studying change processes, including qualitative and quantitative, single case studies, and group designs. In the field of psychotherapy research there are number of quantitative and qualitative research methods for the empirical evaluation of the clients' experience of change. Some of the most commonly used include: i) Kagan's Interpersonal Process Recall (IPR), an exploratory method that stimulates clients' recall by videotape, ii) Elliott's numerous measures such as the qualitative interview protocol measuring client perceived change over the course of psychotherapy called Client Change Interview Protocol (CCIP), iii) the Comprehensive Process Analysis (CPA) method used to investigate helpful, hindering and insight events in psychotherapy, iv) the Brief Structured Recall (BSR) method for collecting and measuring information on significant therapy events, or v) Hermeneutic Single Case Efficacy Design (HSCED), a method which allows fuller understanding of the causality in the change process (Lutz & Knox, 2014). However, unlike the interpretative approach, questionnaires, surveys (online, phone, or paper) and other more or less structured methods of enquiry do not afford the researcher the same opportunity to discover the quality that is essential to the nature of investigated phenomenon.

IPA is a qualitative method of inquiry with theoretical underpinnings that stem from phenomenology (Wertz, 2005). Phenomenology, originally developed by the philosopher Edmund Husserl, is a philosophical approach focusing on the world

as is subjectively experienced by individuals within their social, cultural, and historical contexts. While IPA shares some of the characteristics of phenomenology, in terms of aiming to capture and explore in detail an individual's lived experiences, it also goes beyond that in recognizing that the analysis is a product of the interaction between participants and the researcher. For the IPA researcher, understanding the phenomenon from the participant's perspective and the meanings the participant ascribes to events are of central concern (Smith & Osborn, 2008). Consequently, IPA acknowledges that this can be only achieved through an interpretative process, as these meanings cannot be readily available to the researcher. According to Smith and Osborn, "while one is attempting to capture and do justice to the meanings of the respondents, to learn about their mental and social world, those meanings are not transparently available - they must be obtained through a sustained engagement with the text and a process of interpretation" (p. 66).

IPA is underpinned by some fundamental assumptions about the individual and the world (Willig, 2001). IPA has a theoretical alliance with the cognitive paradigm, as it assumes a connection between an individual's thinking, talking, and emotional states (Smith & Osborn, 2008). While IPA assumes narrative is a product of cognition, it does not argue that such narratives are always accurate reflections of an individual's conceptions. Instead, it assumes that the connections between an individual's thinking, talking, and emotional states are complex, complicated by struggles in articulating experience and avoidance of self-disclosure. A criticism of this approach is that the researcher has to base his or her interpretations about the individual's mental and emotional states on what has been said. Despite these concerns, IPA analysis relies on the assumption that meaningful interpretations of individuals' narratives can be achieved and that subjectivity can be affected by social interactions between social actors (Smith, 2004). That is, IPA recognizes the active role of the researcher in trying to understand the idiography of the participant's world and experience.

This process demands a double level hermeneutic, which assumes that understanding can be achieved through interpretation (Packer & Addison, 1991). This creates two levels of interpretation where the researcher interprets the participant's interpretation of an event/experience. Smith and Osborn (2003) described this in the following way: "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make

sense of their world” (p. 51). Therefore, it is not only the studied phenomenon, but also the interpretative activity on the part of the researcher that shapes the investigation. This in some way parallels the very essence of the psychotherapy process that rests on a subjectively experienced and interpreted interaction between the client and therapist. Both ascribe meanings and interpretations; the client, to his or her experiences, and the therapist to the experiences described by the client.

IPA was specifically developed to allow in-depth explorations of idiographic subjective experiences, with particular focus on exploration of cognitions (Smith, 2004). Initially the IPA method was adopted within the discipline of health psychology. More recently, however, IPA has been applied to research in social, developmental, applied, clinical, and counselling psychology. A number of research studies in clinical and counselling psychology, employing IPA, have been published in the recent years (e.g., Biggerstaff, 2003; Biggerstaff & Thompson, 2008; Carradice, Shankland, & Beail, 2002; French, Maissi, Marteau, 2006; Knudson & Coyle, 2002; Rhodes & Jakes, 2000; Touroni & Coyle, 2002). According to Smith, IPA’s increased popularity within various areas of psychological research is mainly due to its “holistic lens, and because its paradigmatic configuration just doesn’t map neatly onto that constructed by quantitative psychology” (p. 48). Smith and Osborn (2003) also point out that IPA is particularly useful “when one is concerned with complexity, process, or novelty” (p. 53). In its unique application to the study of mental health, IPA can provide rich insights into the individual’s subjective experience that cannot be provided through a quantitative medium. That is, it can offer insight into the underlying cognitions, beliefs, and attitudes of individuals and, as such, develop an insider perspective on psychological interventions (Smith & Osborn, 2003). A central aim of the application of IPA methodology to this research is to maximize in-depth understanding of the client’s concept of processes that facilitate change in psychotherapy.

IPA is a more suitable method of enquiry for the current research than other qualitative approaches as it foremost values the participant’s inner psychological world. IPA, unlike discourse analysis and grounded theory, finds strong validation for alignment of verbal reports with underlying cognitions and ascribes strong importance to the nature and essence of the individual’s experience. While grounded theory and discourse analysis are both long established reliable qualitative methods, IPA with its systematic and well-delineated analytic procedures became one of the

preferred research methods within the field of psychology. This is in part because IPA design originated out of the specific need for conducting psychological research into the personal experience of individuals (Elliott, Fischer, & Rennie, 1999; Smith, Jarman, & Osborn, 1999; Smith & Osborn, 2008).

### **Sampling**

The aim of this study was to examine a broad range of client perspectives about therapeutic change, unrestricted to any particular theoretical framework of therapy. It was, therefore, important to ensure the sample captured a broad range of views and ensure sufficient breadth and depth of data. At the same time, in order to conduct the IPA detailed exploration of participants' personal lived experience Smith and Osborn (2008) consider it particularly useful to have relatively small samples. In taking these aspects into consideration it was decided a priori that twenty-four participants would form a large enough sample to capture a cross-section of the general group under investigation, without being too large to prevent a detailed and nuanced level of analysis (Flick, 2002).

The sample consisted of twenty-four participants who had completed a therapy, drawn from two specific populations. The first group consisted of twelve therapists and trainee therapists, and the second group comprised twelve individuals with no formal training in psychology. The proposed differentiation was based on the premise that a broad spectrum of participants provides an information-rich and representative sample. Furthermore, this sample composition derived from findings emerging from the literature. While there is general agreement amongst researchers that studies on client experience contribute to the knowledge base of counselling and psychotherapy (Elliott & James, 1989; Macran, Ross, Hardy, & Shapiro, 1999; McLeod, 2001), it has been pointed out that clients are often unable to make reliable or objective judgments about their therapy; they may consciously or unconsciously distort their reported experiences, and may not be aware in what ways their therapy has been useful (e.g., Horvath & Greenberg, 1989; Paulson, Truscott & Stuart, 1999; Tryon & Kane, 1993). In order to address these issues and obtain an 'insider' perspective, some researchers (Knox, 2008) suggest that a cohort of participants which includes therapists or trainee therapists provides a more suitable study group, as they have access to the descriptive and therapeutic language and have the self-awareness and sensitivity to enable fine-tuned descriptions of their own experiences. Incorporating both of these groups allows for an investigation of a diverse range of



client perspectives, as well as a between-groups comparison.

Individuals who had completed therapy were invited to participate in this study. For the purpose of this study, therapy was defined as use of any psychological technique that has curative or palliative effect on any psychological problems or mental health disorders. Psychological treatment had to be delivered by practitioners who were psychologists registered with The Psychology Board of Australia or counsellors or psychotherapists who were members of a relevant professional body.

In order to guarantee the integrity of the study and to safeguard participants' wellbeing, inclusion and exclusion criteria were established. The inclusion criteria for participants stipulated that they (1) had attended therapy for a period of at least 6 months, and (2) had completed treatment in the past 6-12 months or are in the maintenance stage. Exclusion criteria were as follows: (1) had been diagnosed with psychosis or presented with a high suicidal risk, and (2) had been undergoing psychological or psychiatric treatment at the time of the data collection.

### **Recruitment process**

In order to gain access to the rich descriptive data, participants with relevant experience were targeted. This was ensured when recruiting participants for the study by using purposive sampling, where participants are selected according to the purpose of the study (Benner, 1994; Patton, 2002). The recruitment process occurred over two years. Participants were recruited through a number of strategies, including flyers, email, and word-of-mouth through the following pathways:

1. Online media such as the Curtin University Blackboard announcement section, and websites of the Association of Counselling Psychologists of Western Australia and Association for Psychoanalytic Psychotherapy of Western Australia were utilized.
2. Networks of psychologists in private practice.
3. Health professionals who provide clients with referrals for psychotherapy were also approached and ask to notify suitable individuals. In particular, two general practitioners who make referrals for psychological services were asked to extend an invitation to potential participants.
4. Snowball sampling was also utilized with individuals who had agreed to participate. This process involved asking participants to nominate others who might be interested in participating in the study (Patton, 2002).

### **Ethical Considerations**

All stages of this research project were conducted with a strict adherence to ethical guidelines and the study was approved by the Curtin University Human Research Ethics Committee. These guidelines were provided to participants, both in written and verbal format upon initial invitation to participate in the study and re-stated at the time of the commencement of interviews. Prior to interviews, participants were provided with a detailed explanation regarding the purpose of the study and the nature of the participants' involvement (Appendix A). Participants were asked permission for audio recordings of interviews to be made and subsequently transcribed verbatim. They were given assurance of confidentiality and that this de-identified information would appear in publications, reports, and supervision, and prior to commencement of interviews, were required to read and sign a form of informed consent, indicating their awareness of the research purpose and understanding of the research process (Appendix B). Participants were made aware that, at any point leading up to and during the interview, they could withdraw their participation without providing any explanation or incurring any negative consequences. Adhering to principles of transparency, participants were also informed about the process of data handling, including how data are stored and who has access to it. All data obtained from the participants, including interview recordings, transcripts, interpretations of the interview transcripts and other relevant materials will be stored in a secure cabinet in the School of Psychology and Speech Pathology at Curtin University for the duration of the study. Participants were given a code and no name appeared on the transcripts. Following the completion of the study, data was stored in a secure cabinet at the School of Psychology at Curtin University for a period of seven years, after which it will be destroyed. The research data are regarded as strictly confidential and anonymous, and was used for the purpose of this research only.

Given the potentially personal, intimate, and confidential nature of the research topic, it was conceivable that participants might find aspects of the interview challenging or distressing. In recognition of this possibility, in case additional support was required, participants were provided with contact details for free and/or low cost counselling services across the Perth metropolitan area such as Communicare, Relationships Australia, and Curtin University Counselling Services. In order to minimize any discomfort, it was made clear to participants that they would be given maximum control over the type and amount of information disclosed

during the interview. Bearing in mind that the nature of the experiences discussed in interviews could be highly personal and sensitive in nature, the need for a high level of researcher sensitivity in dealing with the subject matter was of paramount importance. It is relevant to point out that the researcher is a registered psychologist, with seven years' experience in clinical work, including working with multicultural populations. The researcher piloted an interview on a colleague prior to conducting interviews with participants. This allowed the researcher to reflect further on the interview structure and timeline. More specifically, a piloting interview enabled the researcher to anticipate difficulties that might be encountered by participants, for example in terms of question wording or sensitive areas, and to give some thought to how these difficulties could be handled. This process led to further reflections and changes in the wording of some of the interview questions.

### **Participants**

A total of 24 individuals who had completed long-term therapy took part in the study. Interviews were conducted with 19 women and 5 men. The first study group consisted of 12 therapists with 9 women and 3 men. For the second study group, 12 non-therapists were recruited with 10 women and 2 men. The period since completion of therapy ranged from one month to three years, with most participants having completed therapy 6 months to one year prior to being interviewed. The reason for extending the inclusion criteria to 3 years was necessitated by the difficulty recruiting a sufficient number of participants. The potential limitations of doing so are discussed in the final section of the thesis. There were three participants remaining in the maintenance stage and seeing their therapist once a month or once every two months.

Participants undertook therapy for a variety of reasons including trauma and abuse, depression, anxiety, grief and loss, and various relationship difficulties. Non-psychologists differed from psychologists in that their reasons for seeking therapy were mainly symptom-based. This, to some extent, was true of psychologist participants, however they frequently recognized having professional reasons such as developing greater understanding of the process of therapy as well as gaining 'client perspective' and working towards greater psychological self-awareness. On the whole, participants in both groups reported significantly benefiting from therapy on both symptom reduction as well as levels of deeper functioning levels.

**Demographic data.** A questionnaire was administered to participants during

the interview in order to collect demographic data on age, gender, country of origin, and occupation, as well as a set of questions regarding the theoretical orientation in which therapy was conducted and the length and number of different therapies attended (Appendix D). The majority of participants were female (79%) and almost all (87.5%) were from English-speaking background. The table below summarizes the demographic data for the entire sample.

Table 1. *Demographic Characteristic of the Overall Sample*

	Number	Percentage
<b>Country of Origin</b>		
Australia	16	66%
United Kingdom	4	16%
Ireland	1	4%
Iran	2	8%
Singapore	1	4%
<b>Occupation</b>		
Psychologist	9	37%
Counsellor	2	8%
Psychiatrist	1	4%
Software developer	1	4%
Lawyer	1	4%
Nurse	1	4%
Unemployed	1	4%
Business consultant	1	4%
Public servant	1	4%
Court monitor	1	4%
Academic researcher	1	4%
Physiotherapist	1	4%
Architect	1	4%

\* One participant did not provide this information.

The average duration of therapy for the overall sample was 28 months (Table 2). The therapist-participants had a higher frequency of sessions per week (Table 3), remained in treatment for a year longer than non-therapists (Table 2), and had a higher number and of longer duration of previous therapies (Table 4).

Table 2. *Duration of Therapy for the Overall Sample and Each Study Group*

Participants	<i>n</i>	<i>M</i>	<i>SD</i>	Lowest	Highest
Therapists	12	33 months	27.02	6 months	84 months
Non-Therapists	12	24 months	19.54	6 months	60 months
Overall Sample	24	28 months	23.45	6 months	84 months

Table 3. *Number of Sessions per week*

Sessions/Week	Therapists		Non-Therapists	
	Number	Percentage	Number	Percentage
1 Session	10	42%	12	50%
2 Sessions	1	4%	0	0%
3 Sessions	1	4%	0	0%

Table 4. *Previous Therapy for the Overall Sample and Each Study Group*

Participants	<i>N</i>	<i>M</i>	<i>SD</i>	Lowest	Highest
Therapists	12	12.77 months	10.73	3 sessions	36 months
Non-Therapists	10*	5.25 months	7.4	1 session	24 months
Overall sample	22	9.29 months	9.99	1 session	36 months

\*One participant did not provide this information and one participant did not have any previous therapy

Table 5 displays data on the treatments' theoretical orientations as perceived by the participants. It is of interest that 66% of therapist-participants reported their treatment was psychodynamically oriented, whereas only 16 % of non-therapists believed they received a psychodynamic form of therapy. In addition, 25 % of non-therapists were unable to identify the specific treatment modality in which they were treated. This finding is not surprising, as therapists by nature of their training were more able to identify the modality of treatment.

Table 5. *Theoretical Orientation for Treatment Modality as Described by the Participants*

	Therapists		Non-Therapists	
	Number	Percentage	Number	Percentage
Cognitive-Behavioural	1	8%	1	8%
Psychodynamic	6	50%	2	16%
Psychoanalytic	1	8%	0	0%
Self-Psychology	1	8%	0	0%
Existential	0	0%	1	8%

Humanistic	1	8%	1	8%
Emotional/Solution Focused	0	0%	1	8%
Trauma Focused	0	0%	1	8%
Mindfulness/Acceptance Commitment	1	8%	0	0%
Holistic/Eclectic	1	8%	2	16%
Do not know	0	0%	3	25%

**Data collection.** Data collection was conducted retrospectively through individual in-depth semi-structured interviews, with the aim of exploring participants' personal experience of psychotherapy. The extensive length of interviews was dictated by the IPA aim of achieving detailed and comprehensive accounts of participants lived experience. The interviews were conducted using a semi-structured interview schedule designed in line with IPA guidelines (Smith & Osborn, 2008). IPA, while focusing on how participants perceive and subsequently make sense of their experiences, requires the application of a flexible research instrument. Data in IPA research can be collected through various mediums, for example personal accounts or diaries; however, the most widely applied method is a semi-structured interview (Smith & Osborn, 2008). Given the exploratory nature of the current study, this form of collecting data was considered the most appropriate as it allowed the researcher and participant to engage in a dialogue, to modify initial questions based on the participants' responses, and to probe further and allow exploration of the areas arising from the interview. The interview was designed to enter into the participants' psychological and social world and allow participants to introduce material not foreseen by the researcher.

In accordance with the IPA approach (Smith & Osborn, 2008), semi-structured interviews comprise of a set of questions on an interview schedule that guide the interview process. The emphasis in this form of enquiry is on establishing rapport with the interviewee, probing areas of interest that arise, allowing the interview process to follow the interviewees' interests and concerns, and being flexible with the order of questions (Smith & Osborn, 2008). Thus, the semi-structured interview has considerable advantages, as it enables the researcher to build rapport and empathy, provides more flexibility in the inquiry of the subject of interest enables the interview to reach novel and not anticipated areas, and this tends to produce richer data. Further to this, use of in-depth interviews enables the interviewees to

communicate their reflections more freely therefore leading to the emergence of new perspectives.

The interview schedule was organized to include both previously researched and original areas of investigation (Appendix C). The initial two domains focused on general aspects of change, including the process of change and stages of change. The third domain focused on factors that facilitated and impinged the therapeutic process. Significant moments were explored in the next domain, by addressing specific aspects of change including emotional depth moments and cognitive shifts which have not been examined before from the client perspective. The fifth domain addressed client agency. The last domain consisted of client perceptions of problem formation and problem resolution. These two aspects of change have not been previously researched qualitatively and were added to the current study, for the purpose of deriving a comprehensive exploration of client understanding of change and articulating a therapeutic change model based on the client's experience of psychotherapy.

**Interviews.** The open-ended interview questions aimed to provide an opportunity for participants to describe their own experience of the phenomenon of change within psychotherapy and the meaning they ascribed to it.

Participants were interviewed in a place of their convenience. Eighteen participants chose to be interviewed at home, four participants chose to be interviewed at their office, and two participants chose to be interviewed at the university. All interviews were conducted in a manner that ensured privacy. Despite the lengthy interview process, all but one were conducted in one sitting, with short breaks as needed. The interviews ranged in length from 60-150 minutes, with a mean length of 90 minutes.

### **Data Analysis**

IPA analysis is based on the premise that the participant's intended meanings are not transparently available, and can only be obtained through sustained engagement with the interview transcript and a process of interpretation (Smith & Osborn, 2008). There are three main features of IPA that guided this data analysis: idiographic, inductive, and interrogative characteristics (Smith & Osborn, 2008). IPA is idiographic as it enables the researcher to establish connections between predominant themes within and across cases. Therefore, the researcher can speak not only about groups under investigation but also the individuals comprising the

group. IPA also encourages the researcher to engage in a dialogue with existing literature, an interrogation aimed at the illumination of theory. The final and perhaps most significant characteristic of IPA, is its inductiveness. Techniques employed in IPA are flexible enough to allow unanticipated topics or themes to emerge from the data analysis.

The data analysis was a cyclical process consisting of the following stages: the first encounter with the text, identification of preliminary themes, grouping themes together as clusters, and tabulating themes in a summary table (Table 13, p. 261). Interviews were transcribed utilizing professional transcribing services. The transcripts were subsequently checked against digital voice recordings for accuracy. Each transcript was formatted into a table. The table was divided into a text section containing the original transcript, an exploratory comments section, an emergent theme section, and a superordinate theme section for easy and transparent coding and cross-referencing of extracts. The interpretative process of this very substantial corpus of data required a high degree of reflection. Each transcript was read and re-read multiple times, and this process was accompanied by maintaining reflection on my own thoughts about the phenomenon as new details were emerging. This was an interactive process, as it required constant oscillation between my own reflections on the material and immersion in the material itself. An exploratory comments section of the table was used to record these thoughts as they were emerging. One of the main tasks, particularly in the early stages of the analysis, was to remain as open-minded as possible in order to enable engagement with each transcript without pre-emptive assumptions leading to premature closures (Smith, 2004). A detailed explication of the analytic process is provided below.

The first stage of the analysis focused on an initial coding of each interview, starting with one individual transcript and repeating the process for the remaining 23 interviews, alternating between the therapist group and the non-therapist group. Immersion in the data was achieved by multiple replaying of the interviews alongside reading the corresponding transcripts. Initial comments and interpretations were recorded in the column beside the corresponding section of the transcript. At this stage of analysis, it was particularly important for the coding to remain as close to the original text as possible to retain the essence of the original statement. This was facilitated by refraining from using descriptive labels and terms that are prevalent in the existing literature. The extract below provides an illustration of the



process of annotation of the individual transcript at the early stages of the analysis:

**EXTRACT**

*I don't know if it is so much a change of me.  
It is about perhaps more self-acceptance. I suppose it is a  
greater ability to trust that has come out of it and perhaps a  
bit more faith in the psychology profession has helped.*

**CODING**

Self-acceptance  
Trust and faith

After all 24 transcripts were fully coded and the codes clustered into themes, the next stage involved the exploration of themes from both groups in order to identify the emergent patterns. This process consisted of examining themes from the two groups for convergence and divergence in their experiences of the process of therapeutic change. Analysis at this stage focused on exploring the data for commonalities between the codes that could enable them to be linked and subsequently collapsed into broader, higher order themes. This method involved a systematic analysis of each transcript, leading to the gradual development of a list of concepts that were shared by all participants. This stage of analysis revealed only minor differences between the two sub-groups. These differences will be discussed in the second part of the thesis. However, based on the high degree of repetition of shared themes for the two groups, both sets of transcripts were combined into one corpus of data. While the themes derived from this stage helped orient further analysis by providing a thematic template for the subsequent interview transcripts (Smith & Osborn, 2008), in order to maintain the 'groundedness', the analyses and coding of each individual transcript originated directly from the text.

The third stage involved combined analysis of interview transcripts from therapists and non-therapists for higher order themes. Transcripts underwent systematic analysis of emerging themes, with a focus on developing shared emergent and super-ordinate themes across all transcripts. This involved ongoing coding and re-coding of new data by moving to a detailed analysis of the next case, and so on through the whole sample, oscillating between the two groups. A larger collection of extracts allowed for a gradual emergence of a more comprehensive picture of the participants' 'sense-making' of their lived experience of change. This was an iterative process of cyclical rounds of analysis in which the initial codes for participants' data were re-examined. Some themes were omitted, where others were

collapsed into a new, inclusive theme. These modifications typically occurred when a preliminary theme was no longer sufficient in helping understand material. At this stage of interpreting data, of paramount importance was systematic checking of interpretations against the extracts to insure that integrity of the original meaning of each extract was not compromised, in that it matched what the participants were saying. This stage focused on developing a higher order coding that held consistency and meaning across all transcripts. The excerpt below shows the third stage of analysis with higher order codes for this extract.

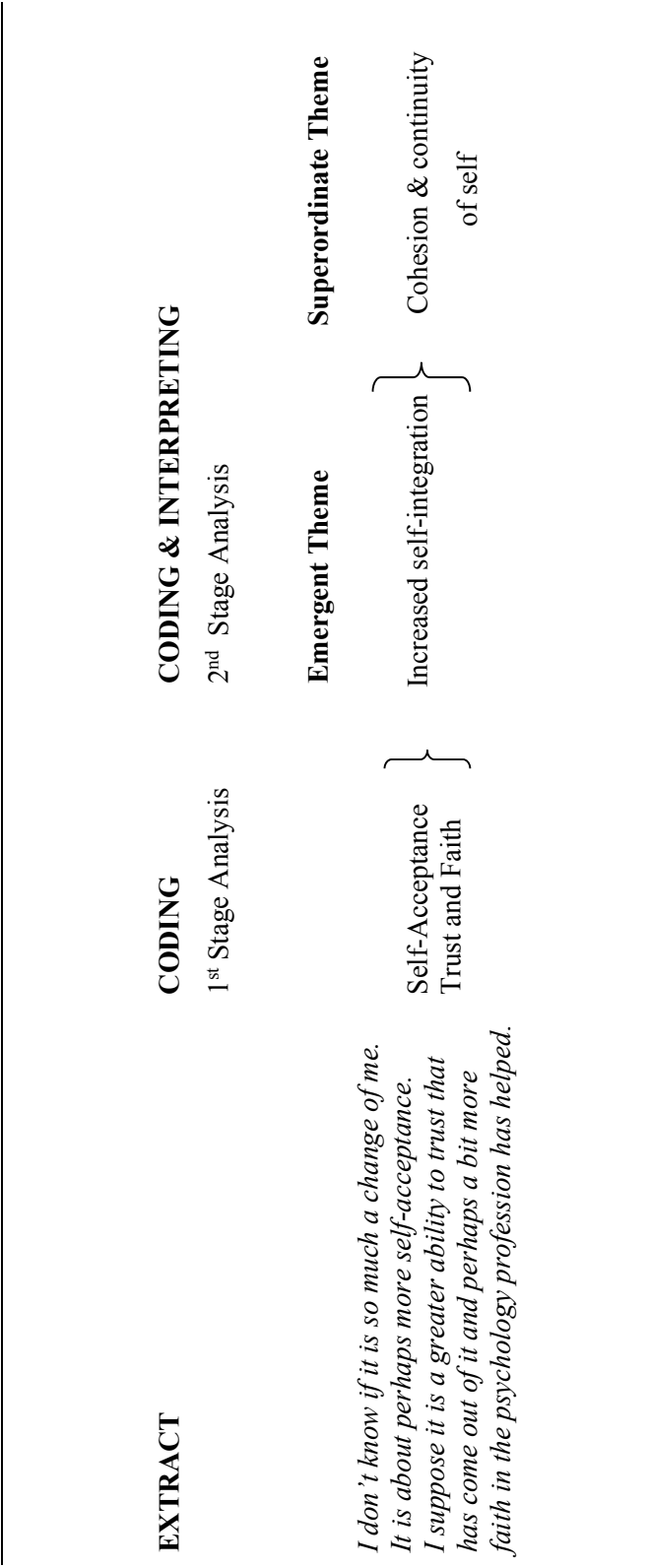


Figure 1. Process of Data Analysis.

All codes were then re-examined across all transcripts to insure that they were meaningfully clustered into shared concepts, reflected within the emergent and super-ordinate themes across all examined domains. Following detailed examination of transcripts for inclusion of all extracts in a new corpus of data, interview data was corroborated into a master table of themes. This table summarized subordinate and emergent themes for each domain examined during the interview. The figure on the following page provides an overview of the stages of the data analysis.

### IPA Data Analysis

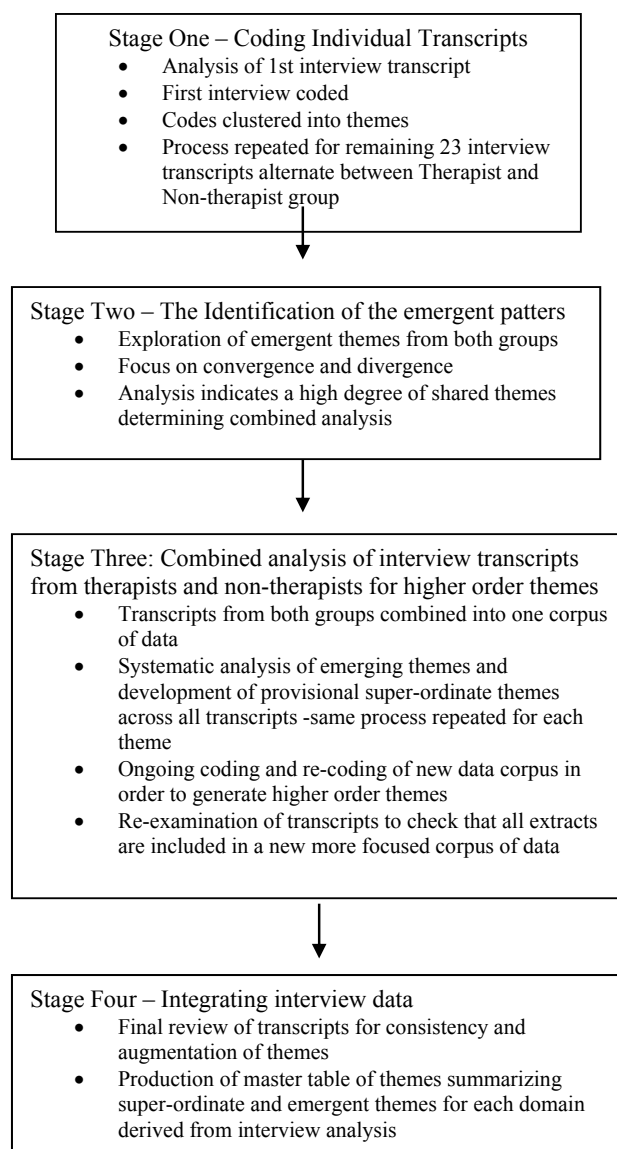


Figure 2. Overview of the data analysis.

The current study adheres to the consensual qualitative research (CQR) guidelines for establishing emergent and super-ordinate theme category frequencies (Hill, Thompson, & Williams, 1997; Hill et al., 2005). CQR guidelines have not been previously applied to IPA. IPA does not have its own format of coding frequency of themes presumably due to its relatively small sample size. However, given that the current sample size would be considered large within the IPA standards (Smith & Osborn, 2008), application of a coding format from corresponding qualitative research was deemed helpful. CQR, based on the number of responses applies the following coding to indicate the frequency of each theme: i) *General* for all or all but one case (23/24); ii) *Typical* for more than half and up to the cut-off for general (12/22); iii) *Variant* for between three and half of the cases; and iv) *Rare* for two to three cases. Results for each domain were presented using these categories in both text and tables. Table 6 illustrates a sample of frequency of superordinate and emergent themes for the process of change domain.

Table 6. *Frequency of Occurrence of the Theme*

<b>Experience of Change</b>	
<b>Intense, growth facilitating experience</b>	<i>Typical</i>
Intense, difficult, valuable experience	<i>Typical</i>
Challenging process that leads to insights	<i>Variant</i>
Deep nurturing experience	<i>Variant</i>

General: all cases or all but 1, Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

### **The Researcher**

A common recommendation, particularly in the field of qualitative studies, is the importance of clarification of the researcher's personal motivation for and role in his/her research (Fisher, 1999; Patton, 2002). Inherent to the IPA method of enquiry is the researcher's subjectivity imbedded in his/her culture and values, which inadvertently shapes his/her analysis and interpretation of the data. Therefore, I would like to acknowledge that in undertaking this project, my professional interest

in understanding dynamics inherent to long-term psychotherapy shaped my decision to research this topic. In addition, my personal experience of undergoing long-term psychoanalytic psychotherapy influenced the way I understood, conceptualized, and interpreted the data. Further, as my own therapeutic orientation is strongly influenced by psychodynamic and psychoanalytic theories it became only natural for me to interpret the data within this paradigm. However, several steps were implemented in order to mitigate any effects of the researcher's theoretical bias, all of which are discussed in the following section.

### **Rigor of the study**

It has been stressed by some researchers (e.g., Brocki & Wearden, 2006), that IPA is highly subjective in nature, as there are no two researchers coming to the same analytical conclusion while working with the same data set. Yardley (2008) proposed guidelines which were applied to safeguard the integrity of this research; these include: (1) sensitivity to context which involved the researcher's capacity for developing a meaningful interview schedule and possessing the necessary skills to build rapport with participants; (2) commitment to rigor which was characterized by full commitment to a lengthy engagement with the research topic, including in-depth analysis of the data; (3) transparency and coherence, which was achieved by regular feedback from my supervisor, other graduate students, and through presentation of the research findings at professional development events and conferences; and (4) impact and importance, including new insights of significance to clinicians, researchers, and other therapy stakeholders. More specifically, the rigor of the study was insured by close adherence to the construct of trustworthiness verified by the notions of credibility, transferability, confirmability, and dependability (Guba, 1990).

Credibility was established through undertaking inter-rater comparisons in which the perspectives of two other researchers (research supervisor and fellow PhD student) were triangulated with my theme coding. Two steps were taken in order to ensure that the analysis was not confined to one perspective, and made sense to other people. Firstly, after I completed coding of the data my research supervisor reviewed it to enable further coding coherence and clarifications. Secondly, another PhD student reviewed one full coded transcript for consistence and coherence (Appendix E). Another important way of maintaining credibility was through conducting disconfirming case analyses. After identifying a set of themes and patterns I engaged

in the complementary process of searching for data that did not fit identified themes and patterns. As Yardley (2008) points out, reporting disconfirming cases serves as a reassurance of level of objectivity in the data and can be treated as one of the indicators of the limits of the generalizability and transferability of the findings.

Transferability requires sufficiently detailed and precise descriptions of data in context (Guba, 1990). Identification of sufficient level of similarities to other contexts may also allow for some generalization onto other contexts (Dervin, 1997). Transferability, in this study, was achieved by providing a detailed description of steps involved in the analysis of the interview data, which was further complemented by a visual overview of the steps, stages, and sequences of the data analysis for the interviews presented in the Figure 1. Provision of this transparent and contextualized analysis of the data should enable the reader to establish connection between the described analysis, experience of individuals in a similar context, and the position current literature takes on the subject under investigation. Transferability can also enable further quantitative research which focuses on the development of psychometric measures of the client's experience of change and the nature of change in therapy.

In order to provide assurance that the research was completed and documented carefully and professionally, an audit trail of data analysis was maintained. Evidence linking the raw data to the final report was maintained by keeping a 'trail' of the analysis, which will allow retracing all the stages of the analysis (Flick, 2009). This includes an electronic document of a completed set of coded transcripts, description of the development of the codes and interpretations, including records of research questions, memos, and notes detailing the reasoning behind analytic decisions (Yardley, 2008).

Finally, in order to maintain confirmability, a strict line of procedures of IPA analysis as outlined by Smith and Osborn (2008) was followed. The IPA method of inquiry requires the researcher to be able to interpret meaningfully how the participant makes sense of his/her world in order to unravel the meaning of the participant's experiences. Those interpretations are based on the researcher's own conceptions, beliefs, expectations, and experiences (Smith & Osborn, 2008). In this respect, IPA requires reflexivity from the researcher and, in order to illuminate the analysis, the researcher is expected to present his or her own perspectives, beliefs, and insights (Patton, 2002; Yardley, 2008). Thus, in order to capture how the

explored phenomenon has been influenced by subjective knowledge of the researcher, an interview detailing the nature of the researcher's own experience of personal therapy was conducted (full transcript of the interview is included in an Appendix F). The interview helped illuminate and clarify the researcher's personal experience of psychotherapy and how it influenced thinking and conceptualizing of the phenomenon under investigation. Further, the research process was well documented and transparently shared with supervisors and academic colleagues. The substantial data corpus (approximately 36 hours of interview recordings) was carefully analysed and supervised by experienced researchers.

### **Methodological Limitations**

The current study was retrospective in nature and relied solely on self-reports of participants. Retrospective reporting can result in important aspects of particular experiences that occurred in therapy to be forgotten or misremembered (e.g., Paulson, Truscott & Stuart, 1999). However, according to Martin and Stelmaczek (1988), clients remembered more than 70 per cent of important events six months after the end of counselling. Another study conducted by Hsu, Crisp and Callender (1992) showed that clients were able to recall significant events even 20 years after the therapy ended. While it has also been suggested that retrospective recalls are vulnerable to many distortions and reworking of historical truth, insight into the way clients have done this can also further our understanding of processes relevant to psychological change (Leuzinger-Bohleber, Sthur, Ruger & Beutel, 2003). It is also likely that the client's informal theory of change will be influenced by the therapist's formal theory of change through the course of therapy. In that sense, the client's theory of change may shift and become increasingly like this of his or her therapist. However, the client may not be able to retrospectively make this distinction. Despite these methodological limitations, it is argued that study designs other than retrospective are inappropriate for examining this particular research topic. For example, initiating interviews at the beginning and throughout the therapeutic process can raise negative implications for clients as well as pose ethical implications for the researcher. Clients entering into therapy are often at their most vulnerable and distressed state; thus, interviewing them regarding problem formation and problem resolution is likely to be experienced as additionally stressful and even traumatizing. Further to this, attempting to inquire about a client's perception and experience of change while they are in the process of therapy can interfere with



therapeutic work and compromise the outcome of therapy. The phenomenon under investigation may in fact need retrospection to gain sufficient cognitive and linguistic comprehension for it to be verbally conceptualized. This notion is consistent with Watzlawick, Weakland, and Fisch's (1974) study indicating that people have great difficulty describing specific aspects of the change process immediately after intervention. Leuzinger-Bohleber, Sthur, Ruger and Beutel suggested that post-therapy recall may be of greater value than accounts obtained at the time of treatment, due to the reduced transference effects and increased distance, both physical and emotional from therapy. Therefore, retrospective recall ought to generate a more objective and full overview of the experience of therapy with clearer perspective of the salient aspects (Baillie & Corrie, 1996).

### **Summary and Conclusions**

This chapter describes the research methodology, including the procedural steps involved in obtaining reliable, descriptive data adhering to the research objectives. Each stage of the research process including recruitment of participants, interview process, and analysis of the interview data was clarified.

The following six chapters (3-8) present the findings. In order to achieve greater clarity and not compromise the depth of the findings this large volume of data was organized into results and discussion sections. The first five chapters provide in-depth analysis of the findings, which were organized into the following domains: experience of change, stages of change, problem formation and resolution, helpful and hindering factors, and significant moments. The list of domains with the superordinate and emergent themes is presented in Table 7 (p. 83). The final chapter brings together all of the key findings from the results section and evaluates them within the context of the existing literature on the process of change in psychotherapy.

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## **PART TWO: RESULTS AND DISCUSSION**

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Table 7. Summary Table of Domains with Superordinate and Emergent Themes

EXPERIENCE OF CHANGE	STAGES OF CHANGE	PROBLEM FORMATION & RESOLUTION	HELPFUL FACTORS	HINDERING FACTORS	SIGNIFICANT MOMENTS
<p><b>Dimensions of change</b></p> <ul style="list-style-type: none"> <li>-Change as continuum</li> <li>-Change as a relational shift</li> <li>-Change as timing</li> </ul> <p><b>Intense, growth facilitating experience</b></p> <ul style="list-style-type: none"> <li>-Intense, difficult, valuable experience</li> <li>-Challenging process that leads to insight</li> <li>-Deep nurturing experience</li> </ul> <p><b>Intra-psyche and interpersonal space</b></p> <ul style="list-style-type: none"> <li>-Being given space for intense focus on self</li> <li>-Silence and time as space</li> <li>-Being witnessed</li> </ul> <p><b>Cohesion and continuity of the self</b></p> <ul style="list-style-type: none"> <li>-Increased self-integration</li> <li>-Becoming more of oneself</li> </ul>	<p><b>Beginning phase: Disorganization and detachment</b></p> <ul style="list-style-type: none"> <li>-Chaos and entrapment</li> <li>-Depression and distress</li> <li>-Unloading feelings</li> </ul> <p><b>Middle phase: From symptomatic to structural change</b></p> <ul style="list-style-type: none"> <li>-Progression from surface to deeper level</li> <li>-Testing newly acquired insights</li> <li>-Experiencing gradual improvement</li> </ul> <p><b>End phase: Consolidation</b></p> <ul style="list-style-type: none"> <li>-Greater authenticity and integration</li> <li>-Self-sufficiency and independence</li> <li>-No emergence of new material</li> <li>-Emergence of more real relationship</li> </ul>	<p><b>Problem formation &amp; resolution</b></p> <ul style="list-style-type: none"> <li>-General sense of problem formation and resolution</li> <li>-Explicit theory</li> <li>-No explicit theory</li> </ul> <p><b>Allegiance and expectancy</b></p> <ul style="list-style-type: none"> <li>-Allegiance to treatment model</li> <li>-Preference for type of therapist</li> </ul> <p><b>Client Agency</b></p> <ul style="list-style-type: none"> <li>-Openness with therapist</li> <li>-Applications in life</li> </ul>	<p><b>Strong therapeutic frame</b></p> <ul style="list-style-type: none"> <li>-Secure therapeutic space</li> <li>-Good boundaries</li> <li>-Predictability and availability</li> </ul> <p><b>Therapist as developmental object</b></p> <ul style="list-style-type: none"> <li>-Containment</li> <li>-Secure attachment and attunement</li> <li>-Experience of re-parenting</li> <li>-Internalization of therapist</li> </ul> <p><b>Very solid alliance</b></p> <ul style="list-style-type: none"> <li>-Acceptance, support &amp; non-judgmentalness</li> <li>-Real and deep relationship</li> <li>-Therapist's qualities</li> <li>-Rupture repair</li> </ul> <p><b>Change facilitating strategies</b></p> <ul style="list-style-type: none"> <li>-General therapeutic interventions</li> <li>-Model specific interventions</li> </ul>	<p><b>Routinized approach</b></p> <ul style="list-style-type: none"> <li>-Rigid preconceptions</li> <li>-Premature goal setting</li> <li>-Mechanized process</li> </ul> <p><b>Hindering technique</b></p> <ul style="list-style-type: none"> <li>-Inaccurate interpretations</li> <li>-Excessive or Lack of structure</li> </ul> <p><b>Impaired therapeutic relationship</b></p> <ul style="list-style-type: none"> <li>-Fear of being judged</li> <li>-Limited attunement</li> <li>-Lack of safe space</li> <li>-Difficult terminations</li> </ul>	<p><b>Transforming experiences</b></p> <ul style="list-style-type: none"> <li>-Moments of insight</li> <li>-Deeply felt emotions</li> <li>-Honesty and realness</li> <li>-Therapist's disclosures</li> <li>-Small realizations</li> </ul> <p><b>Empowering experiences</b></p> <ul style="list-style-type: none"> <li>-Owning and validating feelings</li> <li>-Self-assurance and inner strength</li> <li>-Changes in relational self</li> <li>-Regaining future orientation</li> </ul>

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## **CHAPTER Three**

### **Experience of Change**

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One of the main purposes of psychotherapy is to assist clients with change. The nature of change is defined in a wide array of ways across therapeutic persuasions, including restructuring personality, strengthening ego, helping clients to live more authentically, becoming more differentiated, reconstructing schemas, or changing maladaptive behaviours (Bohart & Tallman, 1999; Boston Change Process Study Group [BCPSG], 2010; Castonguay & Hill, 2007; Duncan et al., 2010; Bergin & Garfield, 1994; Norcross, 2002). Concepts of what constitutes change vary from being highly abstract to very specific. All, however, address domains of feelings, thoughts, and behaviours. This study explored clients experience and the meaning they ascribe to psychotherapeutic change.

This chapter provides an analysis of the clients' overall understanding of the experience of change. This domain reflects the ways in which participants retrospectively theorized their experience of change. Change was characterized by continuity, with considerable degree of unpredictability regarding its course. Participants also considered readiness for change as significant constituent of this experience. This domain also captures some of the key areas that underwent transformation throughout the process of therapy. Participants, in their retrospective accounts, perceived therapy to be growth facilitating, but emphasized the intensity, difficulty, and challenge inherent to this process. Cognitive and emotional understandings of intra-psychic and interpersonal patterns of relating which lead to greater coherence and continuity of self were also experienced as being central to the process of change. In Table 11 the frequency with which the categories of superordinate and emergent themes for the process of change domain are presented.

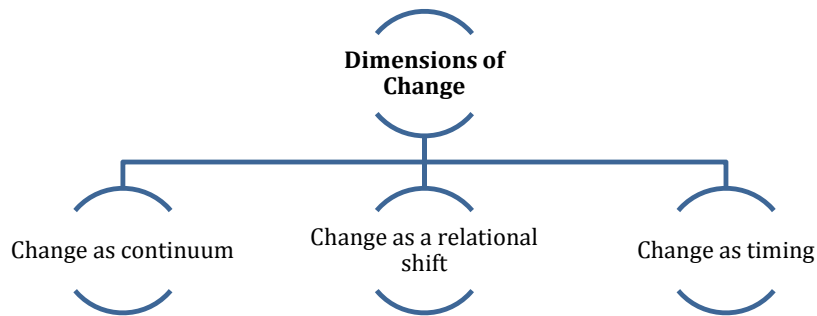
Table 8. *Experience of Change: Frequency of Occurrence of the Theme*

<b>Dimensions of change</b>	<b><i>General</i></b>
Change as continuum	<i>General</i>
Change as a relational shift	<i>Typical</i>
Change as timing	<i>Variant</i>
<b>Intense, growth facilitating experience</b>	<b><i>Typical</i></b>
Intense, difficult, valuable experience	<i>Typical</i>
Challenging process that leads to insights	<i>Variant</i>
Deep nurturing experience	<i>Variant</i>
<b>Intra-psyche and interpersonal space</b>	<b><i>General</i></b>
Being given space for intense focus on self	<i>Typical</i>
Silence and time as space	<i>Typical</i>
Being witnessed	<i>Variant</i>
<b>Cohesion and continuity of the self</b>	<b><i>General</i></b>
Increased self-integration	<i>Typical</i>
Becoming more of oneself	<i>Typical</i>

General: all cases or all but 1, Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

### **Dimensions of Change**

This section addresses the ways in which participants retrospectively theorized their experience of change, and it subsumes four emergent themes: ‘change as a continuum’, ‘change as a relational shift’, and ‘change as timing’. The extent of change was recognized only in retrospect and it was only in confrontation with new challenges that some participants truly comprehended the magnitude of change: “I must say how very much looking back on the landscape is only when I really [recognized] I have changed”.



*Figure 3. Dimensions of Change.*

**Change as continuum.** Generally, participants perceived change as being a continuous process that unfolds gradually over time. Some of the common ways of describing it included: “I didn’t sort of see it specifically about an issue so much as a process, I think”; “continuous, gradual, subtle progression”; “gradual softening and shaping of things”; “unfolding”; “gradual chipping away”; and “not a linear process”. Emphasis was also placed on gradual development of new structures, as opposed to having distinct moments of transition in therapy. This experience was described as a “continuum, where perhaps things sort of spiralled around each other”, or “it was more about just allowing things to unfold rather than really thinking about them too much”. Similarly, participants in Rayner, Thompson, and Walsh’s (2011) study of clients’ experience of the process of change in cognitive analytic therapy reported experiencing change as a continuous process that does not end with formal ending of therapy.

Participants generally did not have the experience of distinct phases leading to specific changes. This was commonly expressed in the following ways: “there wasn’t a moment where I went, ‘Ah hah! Now I get it!’”; “there weren’t any moments that something just clicked”; “I didn’t see it as any particular thing precipitating a massive change at any one point”; “I haven’t got a clear sense of stages, to be honest -it is more fluid” ; and “it is probably a slightly messier structure than a staged notion”. In some cases this process consisted of a number of miniscule changes that occurred and were repeated over time. Change was understood as the cumulative effect of many small realizations. One participant described this in the following way: “change for me comes about by lots of little moments, little jumps,

and little leaps in perspective. The big leaps are no good for me because habits don't change that easily" and later "for me it was the little stuff that tended maybe just to trip me up every now and then". This excerpt illustrates the client's understanding and experience of what generates permanent change. Others similarly viewed this as a circular process of revisiting aspects of self on different levels, often deepening over time: "I can see this is happening now and I am ready to look at that' and then you go back again, until finally you get down to what the core of my issues were, which I would never ever have thought".

Some participants commented that there was a considerable degree of unpredictability in how change shaped its course. Change, in these instances, stood for a cumulative effect of many factors operating within and outside of the consulting room. This was given expression by this therapist-participant:

It bears fruit, it grows to the point where it flowers and the fruits come up. I think those sessions really helped me to be more secure. I don't think it was ever an agenda like, 'Okay, let's work on this now, helping you to be more secure.' It wasn't. It happened as a consequence. I mean, you can't control how a seed grows. You just nourish it. So I guess it was really nourished at the right point and right time.

Change was also perceived as a lifelong process, for example, "it is not something that gets fixed"; "for me, there is never a closure, self-development is a lifelong process"; and "for me, there never was an end ... no, my therapy never really ended". This indicates that whatever came as a result of change was not perceived as final. Participants in other studies also reported experiencing change as an ongoing process that extended beyond the duration of treatment (Rayner, Price, Hotopf, & Higginson, 2011). Findings from outcome research on longer-term therapy also support sustainability of treatment gains over time (Beutel, Blatt, Alimohamed, Levy, & Angtuaco, 2005). Evidence from randomized controlled trials indicates that longer forms of psychotherapy (for example, psychodynamic therapy) often produce long-lasting effects as compared with shorter forms of psychological therapy, such as cognitive behavioural therapy (Fonagy, Roth, & Higgitt, 2005; Taylor et al., 2012). There are also cohort and observational studies that indicate that more durable benefits and continuous improvements may accrue from intensive psychodynamic and psychoanalytic treatments (Leichsenring & Rabung, 2011). This could be explained by the premise on which these longer-term treatments are based, namely, that they promote gradual internalization of psychological capacities, which

allow more active and reflective ways of relating to one's own personal experiences, memories, feelings, beliefs, and relationships. These psychodynamic and psychoanalytic accounts of long-lasting and ongoing changes are further supported by findings from developmental, observational, and neuroscientific studies (Goldberg, 2009).

Overall, participants described change as a gradual process, which requires patience and an environment with potential for deepening psychological work: "I feel like I went in sharp-edged, and with sandpaper we have slowly rounded the edges. I don't recall any saws being brought out and bits being chopped off, yeah, so always in the same direction, but, yeah, never anything huge". Change is also not often susceptible to a highly structured and predictable course of action: "the things that maybe did change, I had no idea that there was anything to change almost, or I had no idea that I would have that outcome instead of this one". Change was also seen as a cumulative effect of various factors, which occurred and were sustained both within and outside of the therapy room: "a lot of the therapy happens outside of therapy, it has been more of a real cumulative process along the way" and "again, it was extra-therapy things that helped me a lot". This is in line with the extensive reviews of outcome research that lend support to the conclusion that change is highly influenced by client characteristics and circumstances outside of therapy (Lambert, 1992, 2005; Norcross, 2002; Wampold, 2006). These factors, known as extratherapeutic factors, account for as much as 40% of change and encompass all that effects improvement outside of the treatment context. They include readiness for change, strengths, resources, level of functioning before treatment, existing social support network, socio-economic status, personal motivations, and life events (Duncan et al., 2010). Research on the factors promoting recovery in 'untreated' individuals indicates that the process of change is promoted by supportive relationships and informal helping systems including: family, friends, clergy members, self-help literature, and self-help groups (Finch, Lambert, & Brown, 2000). It was, however, further acknowledged by some participants that it is often impossible to say what change is and what stimulates it. This participant viewed change in relative terms and pointed out the insolvable difficulty of knowing to what extent change occurs as a result of therapy versus other factors:



If you say somebody is changing over an experience of psychotherapy, who can say that is related to that psychotherapy? And even if related to that psychotherapy, who can say to what aspect of that psychotherapy?

**Change as a relational shift.** Typically, participants acknowledged undergoing changes in ways of relating to self and others by developing new understandings about presenting issues: “I just couldn’t see how I was going to see it differently, but I did learn to see it differently, and that was a huge thing”. The emphasis was also placed on the process of achieving new insights through “testing” their understandings within the context of therapeutic interaction. Some participants described this process as “co-emergence of understanding”. This is echoing the concept of transformation conceptualized, first introduced by Kohut (1971) and expanded by Lachmann (2008), as the bi-directional co-creation of understanding; the nature of this process is explained by Gadamer (as cited in Stern, 1985, p. 211) in the following way: “Because of the very nature of understanding ... it cannot be taught. It happens; it is unbidden. Understanding takes place in dialog; it requires the involvement of two parties, it goes on in the present moment”. Development of new understandings was often seen as needing to originate from the clients’ ways of thinking and feeling about their own circumstances, “to me it must start with, it has to start with, the person’s territory, the person’s view of it”. This is in line with research emphasizing the centrality of the client’s frame of reference and world view in generating therapeutic change (Bohart & Tallman, 1999; Duncan & Miller, 2000).

Analogous to other studies, participants reported changes in the sphere of personal and intimate relationships (Higginson & Mansell, 2008; Rayner, Price, Hotopf, & Higginson, 2011). Therapy assisted participants in developing more satisfying ways of relating to others, “[therapy] has allowed me to have a much deeper and honest relationship”, and “it has led to very tangible changes in the way that I relate with my partner, and it’s enabled a much more open and honest dialogue between myself and others”. Participants also reported profound changes in the way they were experiencing themselves in relation to others. In part, these new insights resulted from questioning certain assumptions and testing them outside of the therapy room: “so, for me, that environment of talking about the change and then experiencing the change is quite powerful”; and “It wasn’t something that I had done. It was the way these people are, that they were manipulative. I learnt how my behaviours support that manipulation”.

Change also occurred in the ways participants conceptualized themselves, a finding also present in the research on clients' experience of personal change and recovery carried out by Higginson and Mansell (2008). Participants in the current study reported developing new ways of understanding their own experiences, which often took the direction of an expansion and deepening of the construct of self: "there were things that I guess I could never escape, but now I know that that is true ... realizing that that is just part of you and it is actually not a terrible part"; "there is certainly more of a capacity to acknowledge and be with and go through those emotions"; and "so, there were things that I maybe wanted to change that you can't change, but it is the way you think about them that changes". There was a greater self-acceptance and normalization of feelings; also as a result of exploring personal history, participants often developed a new narrative about its meaning. These changes in self-perception also required new personal schemas, "my perception of myself shifted and so in that respect new ideas were necessary". Existing research provides strong support for the significance of establishing new schemas and/or transforming existing ones as being central to therapeutic change (Castonguay & Hill, 2007).

**Change as timing.** Less than half the participants acknowledged the relevance of timing for a positive experience of change. While conceptualized in various ways, there was a consensus about the significance of readiness for change: "I think it is just the readiness to accept the change and go with it and look at things"; "I think I finally knew it was time to make a change and I was ready to"; and "exactly what I needed at the right time". Emphasis was largely placed on the ongoing and cumulative nature of change and provision of the right timing of an intervention to accelerate and achieve optimal psychological growth at a given point in life:

And that has not just happened as a result of this therapy. I think some of those seeds got planted a long time ago, but it was somehow things really crystallized. It was not that those things weren't already starting to change or hadn't changed to some degree, but this time around it was much more profound.

In some cases, the foundation was laid through an earlier, usually much shorter, therapy, as it encouraged contemplation and development of motivation for a longer-term and often deeper level of therapeutic work. This notion is consistent with a stage model theory (Prochaska et al., 1994; Stiles, 2001), in which the client moves from the stage of being unaware of the problem towards dawning awareness

and contemplation of the need for change. It is also supported by the theory of the exploring-learning process, (Vygotsky as cited in Castonguay & Hill, 2007), suggesting learning to be a stepwise process with a greater likelihood of attaining insight after sufficient preliminary work in exploring the components of the problem. Likewise, Hill's (2004) stepwise model of the therapy process assumes that deep insights only occur as an extension of preparatory insights where exploration precedes understanding. This is consistent with the data from the current study:

It took me a long time to get to both of them [issues], particularly the last one because I hadn't even told her. I had probably been going for four-odd years and I hadn't even mentioned the car accident, and it just happened....I thought, 'I have put that away and I have dealt with it.' I obviously wasn't ready to get that out and look at it.

Participants' emotional maturity was emphasized as one of the key factors in readiness for change: "because of my age, which meant that I knew that this was my time to do some of this therapy"; and "time and maturity and personal understanding made this therapy more powerful than it would have had I seen him when I was 22". Another critical component of the readiness for change was internal motivation, the importance of which has been emphasized by a plethora of studies (Fraser & Solovey, 2007; Prochaska, 1999). Some therapist-participants recognized that motivation was initially stimulated externally through supervisor-supervisee interaction, in which the supervisor suggested personal therapy to the supervisee.

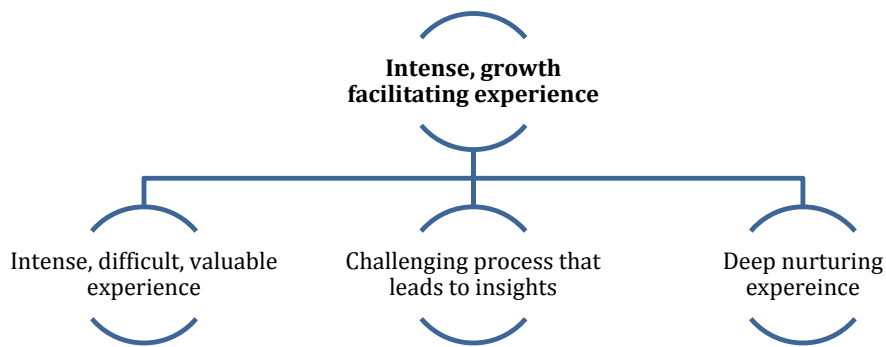
Participants also spoke about the readiness for an active application of skills and knowledge in improving their own circumstances: "the changes have come about by me having to actually make a real attempt at changing the way I look at and do things"; "I made a commitment to myself to give the therapy priority in my life, so he did his job but I also did mine by committing myself to go there even if I didn't feel like going"; and "In the end, the client does have to put some effort in. There are no magic pills.... taking time each day to just go into my room and do some practice of some of the things he was teaching me".

Readiness for change also came with costs of its own, namely, the realization of the lost opportunity of becoming more self-aware earlier in life. Some participants referred to feeling sadness and grief from not having these opportunities in the past: "there was a point where I did feel a bit angry, a bit like, 'I have wasted a lot. If I had known earlier, would I have made different decisions?'". For others, strength and confidence needed to be solidified before they were able to make use of therapy. In

these cases, having sufficient accomplishments in life paved the way for taking risks and acknowledging areas that required work. It seemed that for some participants vulnerability was born out of confidence, “I felt so strong in most aspects of the rest of my life ... but I could see that there was something that was missing, something that needed work”.

### **Intense, Growth-facilitating Experience**

Participants described the overall experience of being in therapy as very demanding, but ultimately growth promoting. They perceived therapy as a deeply nurturing process that facilitated mental and emotional growth of mind and a fuller unfolding of personhood. While challenging and difficult at times, therapy was typically seen as leading to valuable insights and positive changes that were long-lasting. Participants emphasized different aspects of this intense experience.



*Figure 4. Intense, Growth-facilitating Experience.*

**Intense, difficult, valuable experience.** Participants recognized the therapeutic process as demanding significant effort and work, but which brought meaningful changes to their experience of self and others. Their experience of being in therapy was typically referred to as very valuable, beneficial, and liberating, despite being confronting, emotionally painful, and very challenging. This notion of viewing change as difficult process that is not smooth in its essence is well illustrated in the following excerpt:

I know it is very, very difficult for me to change, and I suspect it is the same for most humans on the planet. It is an incredibly difficult thing to really change long-term, and, yeah, I think it needs to be continual and semi-gradual, but I think it always comes in little jumps, those little realizations, yeah, just over time.

There was also a relationship between emotional pain and liberation expressed by number of participants, similar to that reported in other studies (Elliott, Watson, Goldman & Greenberg, 2004; Pascual-Leone & Greenberg, 2007). These researchers suggest that the process of change occurs through the experience and synthesis of opposing emotions. In other words, it is the co-activation of opposing emotional schemas, which through synthesis leads to higher-level integration.

Some participants viewed the experience of therapy in more fundamental terms, emphasizing the lifesaving and life-transforming aspects. Therapy in these cases was a “turning point” in understanding one’s predicament and implementing long-lasting changes. It was a meaning-making endeavour through which new vital psychological structures emerged. The process where an individual organizes their internal psychological structures requires ongoing negotiation of a complex array of polarities that constitute the system (i.e., inclusion of positive and negative aspects of self) (BCPSG, 2010; Klein, 1946; Sander, 1995).

In addition to viewing therapy as personally enriching, therapist-participants viewed the therapeutic experience as being professionally beneficial. Similar to that reported in other studies (Macran & Shapiro, 1998; Orlinsky & Ronnestad, 2005), there seemed to be consensus amongst therapist-participants that the very process of coming to know themselves greatly enhanced their own therapeutic work with clients.

**Challenging process that leads to insight.** Therapy was often seen as a confronting and frustrating process, but one that culminated in satisfying personal discoveries. Less than half of participants summarized their experience of being in therapy as a demanding process that ultimately led to insight: “for the most part it was a satisfying experience, at times challenging and confronting, but reassuring and comforting for the most part”. Insight was facilitated through voicing thoughts, without too much censoring, and being subsequently challenged and provided with a different perspective:

You get challenged if you are saying contradictory things...because by saying some of the things that are going on inside of my head out aloud, which you can’t normally do, you kind of put them into perspective. So, once you say it out aloud, you kind of go, ‘Oh, that didn’t make sense. What I am rationalizing in my head actually doesn’t make sense’, and it is not until it is out. Once you say it out loud you can kind of get a real clarity around it, so that is where the insight probably comes in.

Voicing one's thoughts was reported to promote reflection and development of new meaning; it was this process of integration through naming that generated psychological change. This is in line with previous research on the mechanism of change that indicates that voicing one's thoughts leads to illuminating and amplifying the inner domains, which, when acknowledged and understood, assist with the formation of psychological insight (Castonguay & Hill, 2012).

As mentioned by some participants, the process of change was experienced as difficult as it led to periods of doubts as to the occurrence of the perceived change. Some participants found the process challenging, as they were unable to see any immediate benefits:

I think, a lot of times I was going through the process and thought, 'Am I benefitting? I go and I go into quite a lot of distress and I come away feeling good for it. Is it doing any benefit?' and then over time I could definitely see that there was benefit from it. I would say maybe six months that I really felt like I could see the benefit in the bigger picture rather than just feel a little bit of relief each time I left.

The process of therapy was also seen as a challenging but satisfying experience in which a sense of excitement arises from self-discovery. Participants acknowledged that this sense of self-discovery was generated through an increased focus on self which, in turn, enabled access to deeper parts of the self. Becoming the focus of one's own attention was at the same time experienced as very challenging. In these instances, the discomfort appeared to be generated, not only by the very process of self-exploration, but also by the material arising from it. While central to change, this shift from outer to inner domains proved to be very difficult and initially was experienced as unnatural and confusing. Some theorists argue that this process activates opposing forces with emotional pain and a sense of vulnerability on one level and excitement and liberating insights on another level (Brenman, 2006; Messer & McWilliams, 2007; Waska, 2006). These two opposing dimensions are illustrated in the following excerpts:

Once I got sense of what was going on and knew that I had to make some changes, making the changes was really, really frightening, so there was a lot of fear. I had a lot of fear come up, to the point of some really irrational things happened. I felt really irrational .... I was really frightened that someone would harm me.

At times it might be a challenge ... but even that challenge is so deep within you that I find it more encouraging, more involving, and I like it

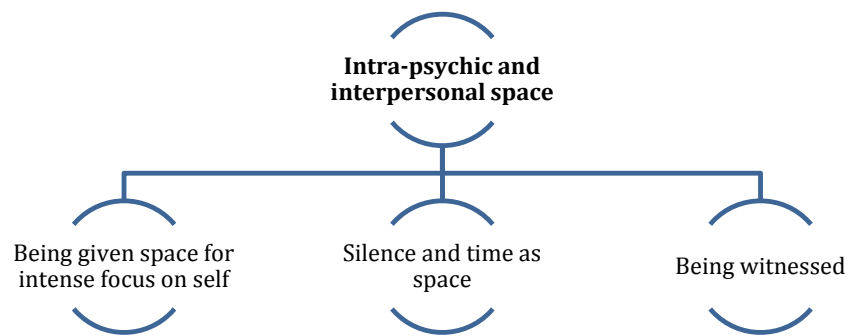
**Deep, nurturing experience.** Participants described the experience of therapy as having an emotionally nourishing potency. Less than half of participants reflected on their experience of therapy as being deeply emotionally nourishing. In the context of the therapeutic relationship, they experienced a sense of being cared for in an emotionally reparative way: “The process of being in therapy, for the most part, was one that I looked forward to, was pleased to have the intimacy that a therapeutic relationship could provide”. Another participant expressed this in the following way:

It is like this sort of core energy that has been touched but in such a way that it has been looked at, it has been touched and held very carefully, and being cared for by somebody else which leads to perhaps that nurturing of it. Perhaps it is a little bit like having a relatively fruity mother and not ever having that as a child. Perhaps that is part of what to me it seemed like. It was like that infant attachment, which is something that you can actually take with you and tap back into at times.

Therapy for these clients went beyond symptom reduction, in that it offered them a developmentally corrective experience. The reparative experience took place at early developmental levels and ultimately led to internalization of the nurturing function (BCPSG, 2010; Fonagy & Target, 2002). The assertion here is that the therapy provides growth-promoting conditions that enable fuller development of self; as Symington (2012) puts it “the task [of therapy] is to bring an infant into adulthood; to create the *I*” (p. 2).

### **Intrapsychic and Interpersonal Space**

Participants emphasized the importance of a psychological environment conducive to acquiring inner knowledge. Generally, they indicated the significance of the provision of space to process material and raise awareness, the provision of silence and time, and the therapist’s emotional presence as important factors in allowing and sustaining the process of accessing internal structures of the self.



*Figure 5.* Intrapsychic and interpersonal space.

**Being given space for intense focus on self.** This emergent theme highlights the significance of the development of conditions that assist clients in accessing their internal self in order to raise self-awareness. Typically, participants indicated that therapy provided conditions necessary to experience a sense of space, in which they could develop a sustained focus on self, process things, and raise their own awareness. There are a number of components to that space which included: the person of the therapist— “not just a physical space, space is created by the place, the person of therapist”; safety—“a space you can go into and feel safe and accepted and not judged”; nurturance—“it was a semi-nurturing sort of space, the nurturing in a way to raise your own consciousness or awareness of what is going on and what I might need to do”; emotional expression—“being able to unload everything that you were feeling in a safe environment”, and “I cried a fair bit and I felt I could do that. I felt I had the space to do it”; acceptance—“ being able to sit with whatever it was that was happening”; emotional freedom—“it helped to create a space where all thoughts, comments and emotional reactions were visible”; emotional space— “allowing lots of space for someone just to kind of put all of their inner world out on the table and then sort of examine what is there”; and internal sense of time—“an internal sense of being given space, never crowded, rushed, or pressured”. Participants recognized that having this safe space was a prerequisite to deeper psychological work. Previous research highlights the importance of creating psychological space as a means of facilitating expansion of consciousness (BCPSG, 2010; Sander, 1988)



The complexities of these different dimensions that constitute the sense of space are illuminated in the following excerpt:

Be allowed to sort of tease my way through it and just see like the murky waters until you find these little whirlpool things that maybe go around until they merge into each other, and allowing me the space to do that without having to almost justify all that, and how long actually this would take. 'This can take as long as you want.'

Some participants indicated that the provision of space, while experienced as challenging, often facilitated the emergence of core psychological issues. One participant described this state of internal focus as “stillness” that facilitates the emergence and deepening of psychological experiences. Some theorists (Bion, 1962; Sander, 1995) identified this process as central to accessing the underlying psychological structures. Some clients have experienced this space as a place where they let go of some degree of control and began working on a deeper psychological level. Also, the co-constructing was possible with therapists who were recognized by the clients as skilled and competent in providing the necessary level of safety.

For therapist-participants, this experience had both a personal and a professional dimension. Experience of the intense focus on self-help developed greater insight and sensitivity to these types of experiences in clients. Similarly, Ronnestad and Orlinsky (2006) reported that the therapist’s experience of personal therapy fostered emotional capacity, which, in turn, promoted an empathically attuned relationship with the client.

Focus on self was also facilitated by the presence of another person. In this context participants were emphasizing the wordless aspect of therapeutic presence. This elusive process consisted of registering and recognizing oneself through that which is reflected by the therapist. This ‘oneness’, the experience of self, is founded on ‘two-ness’, the experience of self being reflected by the therapist (BCPSG, 2010; Beebe & Lachmann, 2005; Symington, 2012). This was well captured in the following statements: “I guess it is when someone sits with me that I can sit with myself”, and “being open to myself and being seen, enabling awareness that is not available in other ways ... When a therapist sees us we have a way of seeing ourselves”. This is an illustration of true self-experience, and as such holds a profound importance to our understanding of the clients’ experience of change. Winnicott (1958) takes up this notion in his ground-breaking paper ‘The Capacity to Be Alone’:

Although many types of experience go to the establishment of the capacity to be alone, there is one that is basic, and without a sufficiency of it the capacity to be alone does not come about; *this experience is that of being alone, as an infant and small child, in the presence of mother*. Thus the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone else is present (p. 416).

This further stresses the potency of therapy as a vehicle facilitating the self-experience that got dislocated, hidden, or even failed to develop through the environmental impingements in infancy and childhood. Participants also highlighted the healing potency of being with, and being witnessed by, a therapist who could bear the intensity of the process. Of particular significance were instances where the participants, at their weakest and most vulnerable, were experiencing these states in the presence of the accepting, yet neutral therapist. Geller, Greenberg, and Watson (2010) defined therapeutic presence as “bringing one’s whole self into the encounter with clients, by being completely in the moment on multiple levels: physically, emotionally, cognitively, and spiritually” (p. 599). In their research on therapists’ and clients’ perceptions of therapeutic presence, they found that there is a predictive relationship between clients’ perceptions of the therapists’ presence (but not the therapists’ perception), which relates to positive change and sense of therapeutic alliance. This was irrespective of theoretical orientation of the therapy.

**Silence and time as space.** Another emergent aspect of the therapeutic process was the provision of a particular form of attention in which psychic activity is withdrawn from the outside and directed inwards. Some participants reported the significant role silence and provision of time played in their own process of change. While more subtle, this form of being with the client appears to facilitate deeper self-examination. Some of the most common aspects of this theme included therapist’s stillness and allowance of time. One participant stated, “they were sensitive to the pacing of the emotional depth that was required of that kind of conversation. They didn’t rush”. Another participant highlighted the significance of “the time and space to not have to answer questions or get to a specific point, being able to sort of sit for a while with things within the session itself”. The experience of not being rushed was significant for many participants:

I found my therapist particularly silent sometimes. And, I mean, sometimes that would annoy me and sometimes it would be nice just to be able to think and gather my thoughts and say what I wanted to when I was ready. So, there is that sort of space, but I think she never sort of—what is the word?—emotionally or energetically intruded. I think, as well, even not being in her direct eye line sometimes gave me space.

Space produced by silence and time differs in quality as it stimulates concentration of psychic energy and encourages attending to the object of self (Nacht, 1964; Perelberg, 2007). The silence of the therapist, a particular form of listening, has been recognized as a very important part of the therapeutic process of change (BCPSG, 2010; Perelberg, 2007).

Some participants also acknowledged the challenges that came with the experience of silence and space. They spoke about the importance of perseverance despite initial discomfort. For example, one participant emphasized difficulties arising from “being the centre of focus” and in the presence of “someone who is really still” with them. Despite being challenging and uncomfortable, this state enabled deeper delving into the mind. In these instances, provision of space and time became an enabler of profound self-discoveries and the catalyst for deeper expressions of feelings (Brenman, 2006; Bion, 1963; Perelberg, 2007).

Within analytic literature, silence is often viewed as an integrative and deepening factor (BCPSG, 2010; Bion, 1963; Nacht, 1964). That is, silence is seen as an indispensable assistance for the language, because in silence its full significance and efficaciousness can be best realized (Nacht, 1964). The verbal relationship between the therapist and the client requires the concurrent presence of a non-verbal relationship, which provides necessary overtones and undertones. In other words, the quality of the non-verbal relationship derives its significance and depth through the existence of a certain quality of silence (Sander, 1995).

We would sit there and the therapist would say something or ask something or make a comment and I would take two or three or four or five minutes to think about it or whatever, and I didn't feel I was rushed or anything, you know, and just to let things settle until there was an answer.

It has also been emphasized that in order for the client to be able to tolerate silence and use it therapeutically, the therapist must be capable of it within themselves (Bion, 1963). This was confirmed by participants, who reported having been able to experience states of deep quietude because their therapists were also capable of enduring silence. This finding finds its confirmation in some more recent studies on uses of silence (Ladany, Hill, Thompson & O'Brien, 2004; Sharpley, 1997). Sharpley found that greater use of silence was associated with clients' trust and confidence in therapists' skills and greater rapport. In the research conducted by Ladany et al. (2004), therapists reported that their own personal experience of

enduring silence and experiencing it as therapeutic was a prerequisite for the use of silence with clients:

Even when I felt like sometimes there wasn't any more to give, some silence and some space to think about things got me into it, got me into further directions as well, yeah.

Descriptions provided by participants indicate that certain silences are necessary for growth of an inner deeper state, which can be reached more directly in silence than through speech. This could occur because speech or words are only pointers; they are a secondary form of communication that provides shape to cognitive and emotional states (Bion, 1961; MacMurray, 1957). Silence and space therefore may foster 'felt experiences' of the more nebulous needs, the needs that exist deep within the person in the latent state (Nacht, 1964; Perelberg, 2007). These needs are expressed by a certain quality of silence that is fostered within the non-verbal relationship between the therapist and the client. According to Nacht and Perelberg, silence can play a significant role in the process of psychic integration as it facilitates the client's ability to tolerate certain enduring states of authentic being from the deepest regions of self. It has been hypothesized by these authors that the therapist's verbal interventions will be received in a different manner if the client listens to them from this space of deeper inner silence. The claim that the therapeutic relationship always develops on parallel levels, one verbal and the other non-verbal, is expressed by Nacht (1964): "true therapeutic relationship is first born in the verbal relationship and could not exist without it, but it is the non-verbal relationship which gives it substance and significance" (p. 300). The notion that psychotherapy is not exclusively a verbal exchange has long been supported by theorists and researchers (BCPSG, 2010; Beebe & Lachmann, 2005; Fonagy & Target, 2002).

### **Being witnessed.**

Some participants acknowledged the importance of affective and cognitive states being witnessed by the therapist. For example, positive experience of change required intense feelings being simultaneously felt by the client and being witnessed by the therapist. These two components central to the healing process were described in the following way:

I guess you feel like you are getting your monies worth when you cry in therapy. I don't know, but there is something about having a witness when you feel really vulnerable. You can have a cry by yourself, but for some reason when someone is watching you and just being with you, there is something healing about it, and allowing yourself to just be really exposed. When it is always a private hidden

experience then it kind of concretizes the idea that there is something that should be hidden about you, that there is something unworthy, something ugly or that should be tucked under and away from the rest of humanity. So having someone witness you in a moment that you usually wouldn't dare let someone see and kind of bringing it out to the surface and no-one is running away from you screaming, so I guess it creates that acceptance.

This quote indicates that central to the healing act is the emotional experience of becoming known to other and knowing oneself, which in part is facilitated by the experience of being witnessed by the therapist.

Psychotherapy research adheres to this notion by recognizing a distinct function of the therapist as a curative element in treatment (BCPSG, 2010; Duncan et al., 2010; Castonguay & Hill, 2012; Fonagy & Target, 2002; Bergin & Garfield, 1994; Norcross, 2002). Analytic literature recognizes witnessing, along with holding, containment, and interpretation as central curative factors (Poland, 2011; Ullman, 2006). Ullman argues that witnessing is a type of mirroring, the process in which the client's disclosures are received by the emotionally available witness who allows the remembering of these memories and transforms them into an integral part of the self, which, in turn, facilitates cohesiveness. She emphasizes the significance of witnessing as a therapeutic function, arguing that:

It enables the creation of the previously untold story, and it is the gaze of the other who does not know yet with his or her readiness to hear, understand, and take the risk of finding his or her own safe assumptions unsettled – that makes the testimony possible (p. 190).

Witnessing is a form of listening and being with the client which often is required for the release of a hidden story and validation of both the client's subjective and external reality (Poland, 2011). Apart from allowing for self-validation, listening and witnessing also assist the client in the evolving of alternative self-experience (Poland, 2011), as seen through the following excerpts:

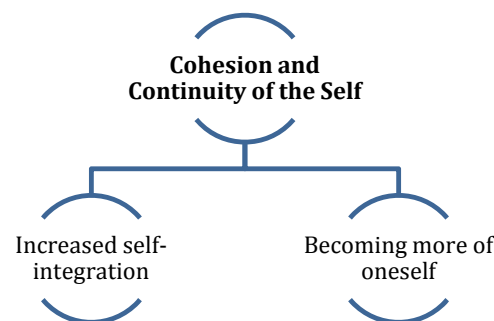
To me, one of the things, and don't get me wrong, I think cognitive therapy can be very helpful and I could probably have sat there and done all the head stuff really easily, not a problem. But it was about actually allowing those emotions up, sitting with them with somebody who could accept me with those emotions, and allow them to subside, come up, subside, allow that part of me to grow to start matching what I thought and not just thinking it and saying it and pushing those emotions down because they are not really matching. And even behaviourally, you know, I think I can do the right things. I can look after myself. I can do this and that, but that internal stuff just still, perhaps it was just underdeveloped. This shell that you built around yourself with all the theory and what you do and all the rest of it, that shell, and perhaps that's what it was. Maybe that's what it was at the end, just about filling me up and everything just felt full, matched, balanced, but it was contained. And

that may change. I think about certain things sometimes, but I think that matching [head with heart] is just so important for longer-term outcomes.

This type of witnessing in which the therapist is willing to know, initiates the process of regaining the sense of self or “I” in the dialog, and subsequently in the centre of the client’s experience (Poland; Ullman, 2006). This promotes the process of “the erosion of the dissociative barrier” (Ullman, p. 191) enabling a psychic transformation. This dimension of psychological development has been extensively studied within the field of attachment, intersubjectivity and neuropsychology, providing compelling evidence for the significance of relational co-constructions of meaning (Beebe & Lachmann, 2005; BCPSG, 2010; Fonagy & Target, 2002; Hobson, 2004; Schore, 2003).

### **Cohesion and Continuity of the Self**

This theme focuses upon the signs of integration that assist the process of growing self-awareness; important aspects within this domain were the processes of developing a more cohesive self-structure, a greater sense of integration, a sense of permanence, and development of new meanings. Generally, participants described self-cohesion and continuity as a felt experience where all the features of one’s personality were experienced as facets of a single, well-integrated structure; this, in turn, was reflected in a stable, positively valued, and congruent set of qualities, ideas, and values. These findings indicating that therapy facilitates inner psychological knowledge which, in turn, promotes establishing greater interior coherence.



*Figure 6. Cohesion and Continuity of the Self.*

**Increased self-integration.** This theme refers to the process of understanding and assimilating different aspects of the self which leads to a greater interior

coherence. Typically, participants described different components of self-integration, including changes in the subjective experience of self and others, acceptance of different parts of the self, and the ability to remain present and in the moment. Participants reported that greater insight and self-awareness were key factors leading to increased self-integration. This process of raising self-awareness was described as a way of coming to know the contents of one's own mind and of achieving psychological change. One participant, for example, described this as a state of "calm and rational self-awareness", while others talked about a "sense of clarity", and an increased ability "to be able to get out of the confusion", which had a stabilizing effect. Similarly, Castonguay and Hill (2012) reported that greater self-awareness manifested itself in the client's improved ability to compare, contrast, and evaluate their own behaviour, as well as reflect on self and other emotional states and motivations.

Therapy was typically described as an agent in raising self-awareness, confidence, and insight:

I mean, probably again, one of the major themes right throughout the whole of the therapy was sort of integrating the different parts of me, of my personality. There is a part of me that I present to the world. That is what people see, and I think for a long time, certainly before therapy and for a lot of therapy, that was who I thought I was, and then other parts of me go, 'Oh that's not me' and not liking that part and not seeing it as part of me, but then through the process of therapy sort of bringing all that together and that sort of sense of acceptance of, 'Well, it is all me. I'm not just this. Yes, I am, that is part of who I am, but it is also this is me as well.'

The process through which disconnected elements within the personality underwent integration was described in the following way:

I see it as an opportunity to integrate disparate bits that were hanging around in my head and in my psyche, and the encounter allowed us to bring those bits together in a much more coherent way, and both ... to have a clearer idea about the bits that were firm and solid and the bits that didn't need to be firm. I suppose it is about understanding what some of the important foundational stuff is and then what you can just play with.

This is an evocative illustration of how responsibility for disowned parts when eventually possible facilitated greater integration. The client can feel reassured, for example, if he believes that the therapist is aware of the existence of a destructive part, while also recognizing the affectionate, warmer side to the personality. Therapist assisted these processes by reflecting back to the client unrecognized aspects of self. One participant described this process metaphorically as: "staring into a mirror until I observe and note things that have always been there but to your perception are new."

... the therapist started using a reflection tool to reflect back to me my own self". This is consistent with Sandler and Sandler's (1998) assertion that one of the goals of therapy is "to get the patient to become friends with the previously unacceptable parts of himself, to get on good terms with previously threatening wishes and fantasies" (p. 422). Many therapists and researchers have argued that central to achieving this goal is the provision of an atmosphere of tolerance. Feldman (2006) further suggests that the more balanced interpretations that acknowledge both loving and destructive elements in the client's personality mitigate anxiety that would otherwise compromise the client's capacity for engagement. O'Shaughnessy (1992) also emphasizes that tolerating and taking greater ownership of previously disowned aspects of self rest on the moderation of the anxiety which drives the splitting and projecting. These conditions lead to diminishing the need for denial, splitting, and projection in the client and enable the therapist to address these unacceptable parts of the client's personality, subsequently allowing for its internalization (Feldman, 2006; Fonagy & Target, 2005; O'Shaughnessy, 1992; Sandler & Sandler, 1998).

Through sufficient validation and normalizing of disowned traits, the therapist often facilitated the integrative process:

She valorised the active components of things that I had devalued ... the aggression, the anger, the being big in the world ... the overwhelmingness ... she would say, 'Well, all of these things are important if you are to be a successful person, both professionally and emotionally. It is not that you need to throw away all that.' I think I had the sense that to be different I had to throw away aspects of myself, and she said, 'No, you don't have to throw them away. It is about the sort of moderation of them and to see yourself as this person', which again intellectually I could give somebody else advice about that, but I couldn't assimilate that emotionally.

As illustrated here, for true self-integration to occur both affective and cognitive components require assimilating. O'Shaughnessy (1992) explains that because of the persistently present force of the defence mechanisms, intellectual understanding alone may not be sufficient to promote psychic change. To be able to use new understandings in an insightful way the underlying affect needs to be processed. She therefore stresses that explanatory interpretations alone are not sufficient in facilitating integration. While they may create an atmosphere of mutual understanding and discussion, they may also indirectly communicate the therapist's own anxieties about addressing more directly intense or disturbing material presented by the client.

The process of reclaiming disowned aspects of self was also accompanied by the experience of an enlargement of an inner space. This expansion manifested itself



on the cognitive level through decrease in compartmentalization: "... internalizing that Bell Curve idea, so rather than making more labelling or absolute statements, shifting to viewing it as something that I thought more or less about than other people". It was also manifested on the affective level: "this is a new feeling that I'm not getting overwhelmed ... it doesn't mean to say that I'm never overwhelmed, but I think there is more capacity to tolerate and contain and hold". According to some participants this capacity developed out of the experience of allowing feelings to emerge, being felt, and processed:

All this stuff would come up and I just processed the feeling ... and I feel that it enabled me to sit with certain feelings and be able to talk about certain things without being overwhelmed. I suppose it has expanded that ability to sit with different emotions and accept different emotions on a physical level rather than just on a head level, 'Oh yes, it is okay that everybody feels that' but to actually be okay with feeling that myself. I feel that that is probably one of the most powerful things I have learned.

These cognitive and affective reorganizations lead to a greater internal holding, which generated wider awareness of self:

I have realized that there is so much more about myself that I am not comfortable with, so it is kind of the opposite that you would expect to go to therapy and feel a lot better about yourself, but it has kind of unearthed some realizations, which is good. There is sort of potential for more growth and creativity.

Here, the experience of therapy did not lead to symptom reduction and acquisition of happiness, but instead facilitated the process of coming to know oneself in the fuller sense. This consisted of an ability to recognize and reintegrate into an internal image, both formerly disowned positive and negative aspects of self. Participants also talked about an expansion of internal space as having a greater ability to experience feelings without necessarily having to modify the structure of their own thoughts and actions: "it was more a spectrum ... it facilitated an ability to accept whatever the emotion was, so not necessarily shifting the structure built on top of that, more a comfort with the foundation". This quote suggests that an expansion on the emotional levels, while enabling greater scope of feelings to be felt, promoted change in itself and did not require secondary structural adjustments. This process of internal expansion was further elaborated on in the following excerpt:

Through talking about something, through verbalizing all of the thoughts that were forbidden to a certain extent—...—talking about things that are forbidden and things that are not what you would normally talk about would give you a sense of - - You have got a spectrum and you look all up and down the spectrum and then you can find your balance. If you can only see one end of the spectrum, then you are always off balance ... exploring the whole lot gave me the understanding .... By looking at

the whole spectrum it would then give me the balance of where I sat on it. I became more me. That's what I meant, is that by looking at all the options it means that I can then clarify what I really want as opposed to being pulled around by anyone else.

This participant describes how she came into contact with her 'core self'. In voicing previously denied thoughts and feelings a wider scope for experiencing self was established; this subsequently generated an internal platform enabling genuine experiences. In other words, this process of 'sharing with' another person, contents previously censored, opened an internal space and provided an internal arena for exploration, bringing the client closer to her real sense of self. Similarly, another participant spoke about change in her internal, psychological structures as resulting from the therapist's ability to assist her in 'opening up' and generating internal space to think and feel:

I felt like I had this ... rigid highly structured psychological framework which wouldn't allow me to see myself in that particular way, and that she freed up that and allowed me to think about myself with the same degree of freedom that I was able to think about others, but was not able to do before.

On reflection, participants identified therapy as an opportunity to integrate disparate parts of self that otherwise was operating within them in incoherent and often distractive ways. It was the encounter between the client and the therapist that allowed this gradual reintegration of disowned parts of self, leading to the formation of a more coherent structure. This process 'uncovered', not only a more complete spectrum of self, but also the complex structure it forms within the personality. Throughout this process participants were able to establish with greater clarity the constituents of the core self and distinguish those from secondary formations. This, in turn, dictated the direction of therapeutic changes. Furthermore, the process of self-integration was characterized by an increased accessibility to the authentic parts of the self, finding consistent with psychoanalytic theorizing (Kohut, 1971; Sander, 1995; Steiner, 2006; Symington, 2012; Waska, 2006). Participants reported experiencing states of greater connectedness with deeper and more authentic parts of themselves. It appears that, at least in part, this was brought forward through unconstrained processes of voicing one's thoughts and feelings; this redirected attention from the surface of the issues toward that which was hidden behind. This shift towards experiencing and examining an internal world, while having an integrative quality, also allowed greater engagement with an external world.

Another significant dimension of increased self-integration is the discovery of previously unrealized and unknown aspects of self. Some participants acknowledged becoming aware of many more components of their personality. This points to a very significant notion—namely, that one’s current awareness might often only be an indirect picture or type of manifestation of the real problem (BCPSG, 2010; Symington, 2012). This is also consistent with Bion’s (1962) assertion that these aspects, which may be central to the problem, are largely hidden from the client and only begin to operate within the self-structure as a result of increased self-awareness:

I think I’m more self-aware. I think I have much more insight .... when something is really pressing my buttons, I usually know what buttons are being pressed and why and for what reason and usually where that comes from. So, it is like, ‘Oh okay, here is that old chestnut again’, and I sort of smile to myself .... So there is a lot more insight into what makes me tick, even finding out some of those things that I never realised about myself. It is like, ‘Oh, I do that!’ There was that sort of insight as well. I mean, obviously there were presenting issues that I went to therapy with, but then finding out so much more along the way was also quite important.

Participants also acknowledged gaining greater self-integration, through processing past experiences and establishing a coherent narrative between the past and the present. They emphasized the positive effect of understanding the impact their past had on their current relationships. Through exploring their childhood and patterns of behaviour within their families, they ultimately gained greater depth in understanding their own patterns of interacting. One participant talked about how being able to rethink the past, especially early childhood, improved his relationships with his entire family and had a flow-on effect to other relationships. Another participant reiterated this by saying, “I couldn’t understand myself, but when I understood myself in the context, in the wider context, in the family context, it was astonishing and it made sense to me”.

Participants were pointing out the importance of establishing a link between past and present, between space and time, and between primary and secondary processes. This process of rethinking, re-experiencing, and co-constructing new meanings promotes formation of new patterns of relatedness (BCPSG, 2010; Fonagy & Target, 2002). It is through this process that material belonging to different spaces and temporalities can be brought together and reintegrated in new ways (Fonagy & Target, 2002). The following excerpt illustrates how events from the past, once being processed and realized, have a transformational effect:

It just was such an incredible relief to be able to actually look at these issues. The biggest ones, the oldest ones, were these really old kind of scars that I was taking the scabs off and looking at, so again things that I saw as a kid ... which were horrific really ugly things that kids really shouldn't see...people dying, and I had never spoken to anyone about because I was trying to protect my family. And God knows how! Like, I now have an adult's perspective on things that I didn't. I only had a child's perspective. But, honestly, three years ago I still saw it as a child. I still thought I went outside my house when I wasn't supposed to go outside and someone died. And I was 33, but my capability of looking at the situation was that of a child because I had never really engaged with it. So it was such sweet relief talking about things that I had never ever been able to talk about. But, again, it was so terrifying and so disturbing and so ugly to pull it out and I needed, you know, her expert skill to actually very gently pull it out of me, and it was going to be painful no matter what. There were some really horrific things, and for her to be able to help me has been tremendous.

Bion (1963) speaks of the fact that within the psyche there are often numerous events that are “lying dead” and awaiting to be created. In this instance it was an early childhood trauma that, as pointed out by the participant, was ‘never engaged with’. Once ‘engaged with’, a transition occurred from a state of being a subject to the trauma to a state of being able to manage it from an adult perspective. This points to the activation of a developmental axis where accelerated emotional transformation takes place through dyadic emotional communication (Lyons-Ruth, 1999; Schore, 2002). Hobson (2004) states that the exchange which takes place between the mother and the infant, in which the mother is able to embrace emotional contents and reflect them back to her infant, instead of discharging them, builds the foundation for the same ability to develop in her child. He further argues, in line with many other attachment researchers (BCPSG, 2010; Beebe & Lachmann, 2005; Fonagy & Target, 2002), that the same process can take place in adult relationships. Therefore, the process of being realized and reflected by the therapist can enable the client to embrace his or her own internal states instead of discharging them (Hobson, 2004). For example, clients may expel painful and difficult emotional states of guilt and loss that they are unable to process in a more elaborative form. This state of inner, subjective realization is activated via relation to another person (BCPSG, 2010). This is, to some extent, intimated by the participants in drawing attention to the fact that change does not simply occur on a cognitive or intellectual level but is experienced as a state of merging between emotional and intellectual components, as is so clearly illustrated in the following example:

Well, as I said, it was both the psychoanalytic insights into my psychological being, so giving me a much deeper psychological and emotional understanding which paralleled my intellectual understanding, and I still don't quite understand how I

could talk previously about my childhood and recognize the psychological impact of that childhood on the person that I was, but I didn't feel it. So it was about understanding, bringing together the mind and feeling states.

It is proposed here that the internal process of merging the intellectual and emotional components occurs within the context of one person relating to another. The therapist's ability to relate to the client has a transformative effect, in that it stimulates the internal process of relating between different parts of the client's personality. This is in line with the assertion made by some authors (Bion, 1962; Symington, 2012) that interpersonal and intrapsychic dimensions are two different angles of one reality in which the outer mode of relating is a reflection of the mode of relating of the parts within. This notion of relational transformative effect, while extended into the adult-adult relating, is largely in line with the infant research on emotional development through co-constructing interactions (Beebe & Lachmann, 2005; Fonagy & Target, 2002; Green, 2003; Hobson, 2004). Therefore, it is understood here, that like intellectual and emotional dimensions, the past and the present can exist within the self as either assimilated or compartmentalized. Thus, the process of internal psychological integration of past with present can be facilitated via the relationship between the therapist and the client.

The data in this section describes processes enabling clients to gradually gain a greater sense of their own minds, own needs, and own personalities. Two main interlinked facets of this process of integration included: the experience of reclaiming previously disowned or unrecognized parts of self, and the experience of expansion of internal space leading to greater scope for feeling and thinking. The main catalyst for this process was the relationship in which the therapist facilitated client's openness leading to expansion of and genuine experience of self. Self-integration promoted not only self-acceptance, but also acceptance of others; this extended beyond 'knowing' into having a 'felt experience' of self and other. This points to the conclusion that a newly acquired sense of reciprocity in the personal exchanges stands as one of the measures of the degree to which an individual achieved self-integration.

**Becoming more of oneself.** Participants within all treatment modalities recognized coming to know and consolidate different parts of self as being change promoting. They frequently acknowledged having a sense of becoming oneself, for example: "I got in touch with myself"; "now I am my own person"; "I've learned to

accept all of me and who I am and that in it all I'm okay"; and "before I had this perception of how I think I should behave, what I think I should be doing. Now I think I feel a lot fuller". These descriptions emphasize an increase in participants' self-experience of 'one's own being', which Schore (2002) refers to as the self-organizing capacity of the individual, or using Blackstone's (2007) phrase 'inward contact with oneself'. Similarly, Damasio (1999) speaks of the 'core self' as the defining boundary of the living organism expressed through the maintenance of internal states within that boundary. He further explains that the individual becomes aware of the 'core self' each time the underlying unconscious 'proto self' is modified (p. 174). Therefore, participants' reference to a fuller experience of self might be more than just a metaphor; they might be referring to a self-contact through a special awareness of the interiority of self. This could be 'felt' each time the 'core self' strengthens as a result of greater realization of previously unrealized or unconscious dimensions within itself.

The concept of addressing different parts of self, while well-established, particularly in analytic literature, for a long time did not receive much attention within other theoretical approaches (Dimaggio, 2006). Freud (as cited in Feldman, 2006) pioneered the model of the mind, which consisted of different parts of the personality. Through describing the complex relationship between ego, superego, and id, he portrayed an individual as experiencing different elements, currents, and conflicts within himself. Building on Freud's early models, Klein (1969), Bion (1963), and Rosenfeld (1965), have further elaborated on the concept of conflicting drives and motives of different parts of the personality. Outside the analytic literature, in recent years researchers and clinicians have recognized the idea that the single, coherent identity is made up of a multiplicity of facets (Aron, 1996; Bromberg, 1998; Elliott & Greenberg, 1997; Muran, Samstag, Ventur, Segal & Winston, 2001; Stiles, 2001). Dimaggio, in line with others (Hermans, 2001; Whelton & Greenberg, 2001), views the mind of an individual as comprised of voices that are in continuous dialogue with each other, negotiating and putting together a narrative that forms the self and embodies the character of an individual's self. The data from this study indicates that the notion of the multiplicity of characters or voices within the self is inherent in the client's way of experiencing and conceptualizing their mind, regardless of the theoretical orientation of the psychotherapy.

Participants indicated that the very nature of the process of becoming oneself was manifested through achieving deeper knowledge of various aspects of self which were illuminated throughout the process of therapy. Milner (1987) recognized the essence of this process as “growing out of the uniqueness of one’s own psycho-physical structure and experience ... growing out of one’s own psycho-physical rhythms” (p. 230). In other words, change was not equated with becoming a different person, but instead it was about becoming more of the person one already was. This notion is well captured in the following excerpt:

I didn’t suddenly become a different person ... and it is not like it made me a different person. It didn’t change me from someone who I was to who I am now. It sort of got me more in touch with me in a way. I think I’m still the same in essentials. I absolutely know I’m the same, but it is like doors are open almost in a way now, internally, that maybe weren’t before. I’m just trying to think what it might be like, because it is not like I have ever been diagnosed with depression or anxiety or some other mental health condition where there was a diagnosis and now I’m fixed or cured or put it like that. So, it is not that I was one way and now I’m another. That’s not the case for me at all.

As illustrated here, the process could be conceptualized as the diffusion of false self-organization for which therapy became a conducive environment. This is consistent with Winnicott’s (1974) concept of ‘false self’, which gets organized in reaction to impingements in early environmental care; however, it differs somewhat from Winnicott’s concept of ‘true self’, which implies the pure, unadulterated state reached in ideal circumstances. Instead, based on the current data, it is postulated that the goal of psychotherapy is not to achieve a pure-self system, but instead to diffuse falseness and develop a sense of the wholeness of one’s own self. This echoes Guntrip’s (1971) understanding of self:

When a baby is born, he contains a core of uniqueness that has never existed before. The parents’ responsibility is not to mold, shape, pattern, or condition him, but to support him in such a way that his precious hidden uniqueness shall be able to emerge and guide his whole development. This is a variable factor, stronger in some than in others. It needs the support of a social and cultural environment (p. 181).

In line with this theorizing, participants acknowledged the interdependence of the self and other in the process of deepening their self-contact. For example, they recognized that the process of ‘becoming more of oneself’ was inextricably linked with the experience of being accepted by the therapist:

I suppose it is a greater ability to trust that has come out of it ... there was a part of me that was touched that was never touched before, and it left me with a very empowered feeling and I felt a feeling of being okay, of being me .... that comes down to some of that self-acceptance, but not ever having had that before it was

actually really powerful. It was certainly hard to put it into words, but visually to me it is almost like a light inside was lit.

In addition, this process of ‘becoming more of oneself’ required sustained focus on the self, which generated greater opportunity to come into contact with various aspects of one’s own personality: “the biggest thing about counselling was that I needed time for myself. I needed time to actually like myself and like where I was and what I was doing before I could actually be anything to anybody else”. These excerpts point to the importance of the centering on self both in the presence of, and in interaction with, the therapist. This notion has been long supported by Beebe, Lachmann and Jaffe (1997), who emphasize the importance of inclusion of an intrapsychic view and the contribution of the therapeutic dyad and the environment in promoting a client’s understanding of self.

Furthermore, Mitchell (2000) argues that multiple selves are inherent, inevitable features of normal development. These, however, are vulnerable to fractionation and lack of integration when there is a less than optimal relational environment through which self can undergo processes of integration (Bucci, 2001; Lyons-Ruth, 1999; Stern, 1985; Tronic & Weinberg, 1997). This cognitive-developmental research along with neuroscience findings (e.g., Damasio, 1999; Edelman, 1992) understands mind to be in normal development naturally fragmented with meaning systems often unintegrated and mental processing occurring at several parallel levels. These researchers further argued that the only domain available in infancy that remains throughout the lifetime is the implicit relational knowing, a form of procedural knowledge regarding how to do things with intimate others. This form of knowledge is highly susceptible to fractionation and lack of integration in the absence of empathic relating (Lyons-Ruth). Therefore, it can be argued that therapy, if able to provide a sufficient empathic collaborative relationship, can lead to development of a new integrated system.

One of the ways in which participants experienced becoming more of oneself was through the process of reclaiming previously disowned or unrecognized parts of self, for instance: “getting to know all your foibles and quirks and idiosyncrasies....It was not seeing them as terrible anymore, but reincorporating it or just realizing them and being okay with it and go on living your life in a less conflictual manner”. An ability to recognize what one projects into the outside world constituted a significant part of the process in reclaiming disowned parts of self: “learning about what I



project onto other people ... what I think they might be thinking about me or about situations, and that what I think is not always accurate". This participant also spoke about deeper emotional learning in acquiring a better sense of when she resolved to use specific defensive strategies:

Knowing when I'm projecting. I know what that feels like. I know what the emotion feels and the bodily sense, so I can sort of notice and pull myself back and think about it and go, 'What's happening here? What's pressed my buttons?' and sort of take a step back and a deep breath. That is a valuable learning.

This process extends beyond the awareness of disowned parts of self, into ability for mentalizing (Fonagy & Target, 2005), in that there is recognition that interpretations of others may not always be accurate. In being able to relinquish projections, it appears this client developed better understanding of her own and others' mental states that underlay overt behaviours.

Participants described therapy as a dynamic and often fluctuating process of growth and development that leads to a strengthening of the self. This confirms research indicating that the psychotherapeutic change process is inherently nonlinear and multifaceted (Collins, 2006; Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Vallacher, Read, & Nowak, 2002). For example, participants developed greater self-knowledge and internal resources that enabled them to tolerate the inconsistencies, disappointments, and flaws that life, self, and others bring. The self was described as becoming whole and integrated, the internal experiences more closely aligned with, and matching, the external reality. Many participants accounted for the process of change in terms of the development of more solid internal and external affective and cognitive connections. These findings suggest the importance of processes that enable people to keep developing over a specific model of 'health' and 'normality' (Bohart & Tallman, 1999; BSPSG, 2010; Duncan et al., 2010).

This notion of change parallels a dynamic system theory view of fitness and change (BCPSG, 2010). This theory builds on developmental research and describes change as a "continually shifting process of emergent organization" (Beebe & Lachmann, 2005, p. 229). In line with this view, the therapeutic change inevitably involves work on the affective, cognitive, and enactive levels (Schorer, 2011). This stimulates deconstruction within the old, more negative meanings and patterns of relating into more integrated, flexible, and coherent ways of relating within the self and with others (Lyons-Ruth, 1999). However, for the therapy to alter

the inner emotional structure, the external agency of the therapist is required (BCPSG, 2010). Thus, using an interactive model of mind such as dynamic systems theory enables therapy to be viewed as the process of rewriting and remapping earlier encoded experiences within the relational context (Beebe & Lachmann, 2005). This is supported by neuropsychology research that views mind as inherently relational and its content and the structure as continually updated as a function of experience (Schore, 2011).

This chapter has focused on exploring composites of the process of therapeutic change as derived from retrospective reflections on longer-term therapy. Participants' reflections on the process of change put the main emphasis on its growth-promoting faculty that typically developed through challenging, and emotionally intense, experiences. There was a general consensus amongst participants that being with and being witnessed by the therapist was experienced as growth promoting. They also stressed the importance of being deeply cared for as having an emotionally reparative function, in that it extended therapy beyond symptom reduction into having a developmentally corrective experience. The provision of a safe space and time were recognized as important in awareness raising and prompting self-integration.

This chapter provided a broad outline of the process of change. Firstly, change was experienced as a gradual process, which requires the right timing, patience, and an environment with potential for deepening psychological work. Secondly, process of change was conceptualized as a relational process with a dynamic and nonlinear trajectory and is characterized by the transformations within the following dimensions: (a) growth, in which psychological structures undergo exposure, reorganization, and growth into new structures; (b) integration, in which past events are reactivated and reintegrated with current material, and greater cohesion and continuity of the self is achieved; and (c) an internal stance, in which provision of time and space facilitates exploration of one's own internal world and its external manifestations. The dynamics and conditions of the process of psychological change explicated here, provides a direction of therapeutic action for psychotherapy, which will be further explicated in subsequent chapters.

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## CHAPTER Four

### Stages of Change

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This chapter summarizes the findings pertaining to the participants' experience of the stages of change. In the first instance, the participants identified no stages; instead, they described change as occurring gradually and without any specific points of transition. However, upon further reflection, they were able to identify characteristic features of the beginning, middle, and end phase of therapy. Although the participants experienced different problems and underwent different types of psychotherapy, a number of common elements were identified based on their accounts of stages of change. Three broad stages emerged from these descriptions: i) a beginning phase of disorganization and detachment; ii) a middle phase of progress from symptomatic to structural change; and iii) an end phase of consolidation. Within each of these superordinate themes, the analysis identified several subthemes. Stage of change themes that emerged out of the analysis are summarized below.

Table 9. *Stages of Change: Frequency of Occurrence of the Theme*

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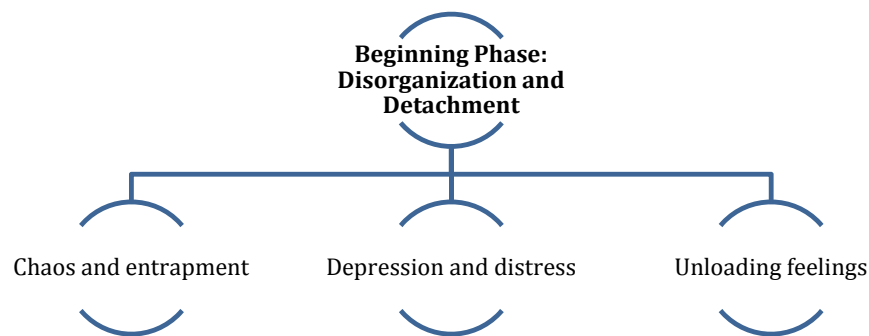
<b>Beginning phase:</b>	
<b>Disorganization and detachment</b>	<b><i>General</i></b>
Chaos and entrapment	<i>Typical</i>
Depression and distress	<i>Typical</i>
Unloading feelings	<i>Variant</i>
 <b>Middle phase:</b>	
<b>From symptomatic to structural change</b>	<b><i>General</i></b>
Progression from surface to deeper level	<i>Typical</i>
Testing newly acquired insights	<i>Typical</i>
Experiencing gradual improvement	<i>Variant</i>
 <b>End phase:</b>	
<b>Consolidation</b>	<b><i>General</i></b>
Greater authenticity and integration	<i>Typical</i>
Self-sufficiency and independence	<i>Typical</i>
No emergence of new material	<i>Variant</i>
Emergence of more real relationship	<i>Variant</i>

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General: all cases or all but 1, Typical: more than half, Variant: less than half, Rare: 2 to 3 cases

### Beginning Phase: Disorganization and Detachment

This theme encompassed emotional and behavioural states experienced in the beginning phase of treatment. Generally, participants experienced this stage of treatment as being quite turbulent and challenging. However, despite this stage being very demanding emotionally, participants also experienced some sense of relief that there was somebody who was committed to helping them: “the really deep part was that sense of relief in the beginning. That enormous relief that she was going to help me was wonderful. That I wasn’t on my own was really important”. The emergent themes in this category reflect change on two levels. The first one is conceptualized as a ‘state of being’ and the second one as a ‘state of doing’. Participants’ state of being is represented by themes of chaos and entrapment, and depression and distress; their state of doing is characterized within the theme of unloading feelings.



*Figure 7.* Beginning Phase: Disorganization and Detachment.

**Chaos and entrapment.** Typically, in these early stages of therapy, participants experienced a sense of lack of direction, confusion, and limitations in dealing with overwhelming emotional states. One of the participants captured the atmosphere generated within these early stages with the metaphor of being lost:

I felt I was lost, but I’m still tracking my general direction, but I don’t have a map. I have a compass. I roughly know where to go in life, but a compass is very rough, so I was just feeling my way through. So she helped me to find a path quite clearly, yeah. So, I think from being totally without any guidance at all, that really provided some guide to where to go, yeah. So I was a bit more lost and then less lost.

These early stages of therapy were often portrayed as states of emotional and physical disequilibrium. Typically, in these instances life circumstances had been

posing significant challenges and disruption for prolonged periods of time. One participant referred to this phase as “the place of chaos and turmoil”. An overwhelming sense of hopelessness, “deep sense of exhaustion”, and disempowerment was often indicated in these early stages. This internal sense of chaos, in many instances, was mirrored by external chaotic and difficult life circumstances:

It was just too much to deal with. So I had my job, my home, my relationship and a really close friendship ended at the same time, and I was seriously desperate in trying to hold it together. So I just went in there desperate for help. I kind of see myself at that point like a little child asking for help, not even knowing what kind of help or who, but just thinking, ‘Maybe this will help, I don’t know’.

A sense of entrapment was also typically expressed within the early stages of therapy. Participants frequently used terms such as “trapped”, “stuck”, and “seeing no way out”. One participant described her experience as “just surviving and staying on the surface of my life” with only “surface deep” skills to manage her situation. Higginson and Mansell (2008), adopting the same methodology, examined the experience of personal change and recovery. Consistent with the current study, the main theme identified at the early stages of treatment included: ‘hopelessness and issues of control’, characterized by the inability to see the future and lack of understanding and control. Participants in their study also used the adjectives such as “lost”, “stuck”, and “trapped” when describing sense of little or no hope for the future (p. 316).

This sense of entrapment was maintained by an inability to successfully address problems. Similarly to other studies (Higginson & Mansell, 2008; Linley, Joseph & Loumidis, 2005), participants often had some general understanding of their predicament, but were lacking in adequate ways of addressing it. A sense of hopelessness and lack of direction was often associated with failing to achieve adequate resolution through application of these problem-solving strategies. This state of “getting nowhere” and “not improving” became the impetus for seeking therapy. In a few instances, participants experienced more severe states, characterized by a sense of detachment, or even self-destruction, or dissociation from both the inner and outer world. This sense of being detached was also experienced on the deeper, existential level, characterized by the lack of meaning and knowledge of the true self. Common to these participants were self-referential statements, such as “I didn’t know myself at all, apart from the longing that I had, and what you think

you are ... mother/wife”; and “I was almost like a broken person. I wasn’t complete”.

These descriptions give the impression of a process of transformation or ‘process of becoming’, which is often entered into through the endurance of some destabilizing and distressing event (Bion, 1963). The phenomenon of becoming who one is has been mainly addressed by existential philosophers (Berlin, 1979; Macmurray, 1957); this process can be facilitated in various ways, one of which is psychotherapy. Freud (as cited in Mannoni, 1985), for example, described processes when the patient comes to realize that he or she had always known what had been revealed. Therefore, ‘becoming who one is and knowing what one knew’, refers to the fact that there is a psychological reality within an individual that needs to be created (Freud). This is the process in which something that has been on the periphery of one’s knowledge comes into the centre (Bion, 1963).

**Depression and distress.** Another dominant experience associated with the initial stages of therapy was an intense emotional state of depression and distress. These painful and overwhelming feelings pervaded this stage of treatment. Participants frequently described themselves as being overwhelmed with affect. Terms commonly used at this stage included: “depressive episode”, “depressive disposition”, “despondent”, “wracked with feelings of guilt and judgment”, “really unhappy”, “mess”, “nervous wreck”, “emotionally labile”, “very scared”, and “high levels of distress”. One participant gave expression to the intensity and the magnitude of this experience in the following account:

I didn’t want to interact. So there were a lot of dark stages ... most of it was in a deep, dark hole. I was on a downhill spiral... I just felt as I started right at the bottom. I had hit rock bottom. I said to my husband, ‘Okay, I’m probably the worst I can be.’ This was right at the start.

At this stage, a number of participants recalled their sense of distress, confusion, and a lack of hope that the situation would improve. This was typically expressed in statements such as “you felt like you can’t get through those feelings ... that you are always going to feel this way”; and “I was desperate to talk to someone. I couldn’t understand what was going on”. Some participants recognized this sense of being overwhelmed as further manifesting itself in a physiological form, saying “I felt heaviness and I was literally physically heavier... I felt heavy in my heart”. For others, experience of depression and distress, in the initial stages, was further

maintained by increasing awareness of the magnitude of their problems. This in turn promoted escapism and denial:

I wanted to just run away from the whole thing because when you start looking at stuff you are scared that if you start it will never stop.

These overwhelming states, however, were not always all-encompassing. In some instances, feelings of powerlessness and vulnerability were aroused only in a specific context in which participants were unable to effect any change.

This phase of treatment was also experienced as a “crisis intervention” and a point of “acute distress” punctuated by frequent cathartic reactions of crying. Typical expressions included: “I was quite overwhelmed with affect”; “I went through a lot of sadness”; “I cried a hell of a lot”; and “I was very emotional about everything”.

Through this destabilization of structures, something deep within the person became exposed and experienced as extremely painful:

I was almost unrecognisable to myself, because I was under a huge amount of stress.... And I probably needed to be under that level of stress, because I had created that image of myself- for myself- of being really tough and really capable and not being affected by these things and being able to deal with really big things and using these really traumatic experiences as examples of things that I had dealt with and wasn't affected by. Yeah, I do think I was very fortunate to have had such traumatic experiences happening in such condensed time periods, that I was desperate and I just needed help.

This excerpt highlights the notion that trauma and adversity often activates resources directed at re-establishing psychological equilibrium. There is strong theoretical and empirical evidence to support the notion that stressful and traumatic events may serve as a trigger to personal growth (Linley et al., 2005; Tedeschi & Calhoun, 2004). Researchers use various terms to describe changes resulting from cumulation of stressful and traumatic events, including amongst others, stress-related growth (Park, Cohen, & Murch, 1996), post-traumatic growth (Tedeschi & Calhoun, 1995), and transformational coping (Aldwin, 1994). The functional-descriptive model, proposed by Tedeschi and Calhoun (2004), argue that the confrontation with traumatic events has a shattering effect on the pre-trauma schemas which, in turn, generates a need for integration of the new trauma-related information. The force of these events is central because the shattering of existing structures that activates cognitive processes (initially more automatic than deliberate), through which attempts are made to understand what has happened and how to deal with emotional reactions to these traumas (Tedeschi & Calhoun, 1995).

Overall, these early stages of treatment, characterized by ‘chaos and entrapment’ and ‘depression and distress’, are reflective of the hopelessness theory of depression (Abramson, Alloy, & Metalsky, 1989). These experiences can also be explained by Seligman’s (1975) learned helplessness theory of depression. Both theories state that depressed individual tends to perceive life events as uncontrollable and may be unable to implement sufficient change generating strategies.

**Unloading feelings.** The need to give expression to feelings predominated the early stages of treatment. Some participants acknowledged the need to tell their story and discharge painful feelings. Common descriptions included a need for “a place to vent” and a “place to tell the story” in the presence of someone who listens. This need for verbalization, in the presence of a therapist, often came with a sense of relief and proved to be very cathartic. Emphasis was also given to the corrective relational dimension: “it was about learning how to actually be heard in terms of my needs and things”. The emphasis was also placed on the therapist’s facilitative role in the emergence of the narrative as well as the complex quality of the emotional aftermath of the process:

It was really about needing a lot of support, just to really be able to talk about what was going on and how I was feeling about it, and help to sort out what my feelings are and different better ways of responding and understanding why I was reacting that way. I can remember in the early stages walking out feeling exhausted and drained and then at other times walking out feeling on a real high. Yes, that was that where there was so much emotion, and just dumping it and getting rid of it, and coming out and, yeah, a lot of crying and sort of thing, walking out feeling very drained but sort of flat and exhausted, but kind of good that, you know, not feeling so wound up.

This excerpt gives insight into the labile and often conflicting nature of the emotional experiences in these initial stages of treatment. These intense emotional configurations may be viewed as a form of emotional ‘unblocking’ that necessitates symbolization of emotional reactions into feelings and words (Sander, 1995). This can be understood as a prerequisite to what Grawe (1997) refers to as “problem actuation”, in which new understandings are reached through recreation of the bodily symptoms and experiences associated with a particular problem. The need for unloading feelings and experiencing their intensity can be also theorized within dynamic system theory (BCPSG, 2010). The transformational process begins with discharging a large volume of emotional content that is experienced as intense and chaotic. This allows formation of a ground for the more organic and less cerebral



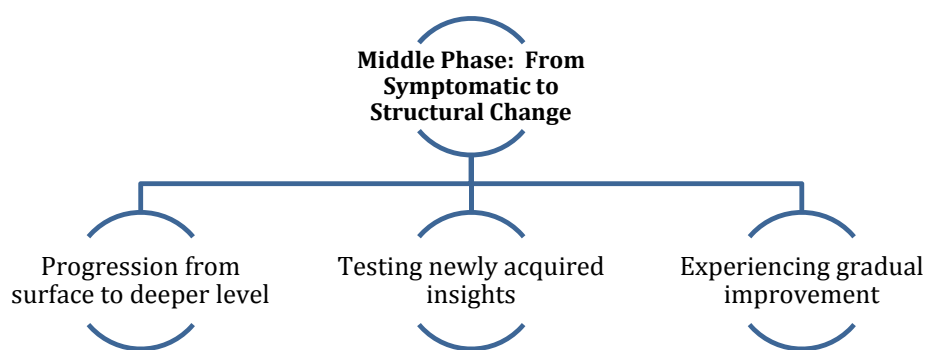
process of emotional individuation (BCPSG, 2010). According to this conceptual frame, there is a gradual transition from undifferentiated and highly fluctuating emotional states to differentiated and more stable states. These emerge in the dyadic context, in this case, between the client and the therapist (BCPSG, 2010). These processes are captured within the following description:

I think it was all very deep. Especially in the early days, it was like coming out feeling like I had been rolled over by a steamroller. It was really intensive and difficult work, I think, because of the therapy involving the experience of affect, it was all experienced very deeply, and I think that was what was beneficial for me was experiencing those things deeply.

Here, the participant claims that although these early emotional experiences were very intense, this depth of ‘felt experience’ was a prerequisite for transformational processes to begin operating within her psychological structures. In other words, emotional individuation (BCPSG, 2010) requires sustaining an ongoing accessibility of affective states, which over time undergo modulations and consolidations.

#### **Middle Phase: From Symptomatic to Structural Change**

The middle stage of treatment was generally characterized by progression from surface level issues to working on deeper psychological levels. Symptom reduction and greater insight into one’s own psychological structure was reported as occurring in this stage of treatment. The emergent themes in this phase included: ‘progression from surface to deeper levels’, ‘testing newly acquired insights’, and ‘experiencing gradual improvement’.



*Figure 8.* Middle Phase: From Symptomatic to Structural Change.

**Progression from surface to deeper levels.** This theme reflects transition from a chaotic state into a less emotionally overwhelming one, which permitted

further psychological exploration. This period was characterized by “dealing with the core self”, “moving from surface to underlying issues”, “slowly spiralling in”, and focusing on “deeper things and different memories and feelings [that] were coming up”. Typically, participants began work on these deeper psychological levels when their relationship with the therapist was strong and reliable and they experienced life as more settled. Also, in this phase of treatment participants were developing enough skill and strength to address the external manifestations of their problems which, in turn, opened up more space for deeper psychological work. However, the progression from surface to deeper levels was not linear but instead an oscillation between these two dimensions:

There probably would have been half the time still sort of bouncing stuff about what was happening, about my world and all the dramas that I had to go through. And probably about half the sessions were on a deep level, by then, where it was really looking at the emotional stuff and the impact of childhood and things that would just come up. Because, of course, there were times when I was a little bit more settled, and obviously I had a bit more room within myself ...but it was good to have the space to allow that as well. So it wasn't just working on that superficial level. It was then starting to, I suppose, work on some of the underlying stuff, as well, which I felt was really important.

The nature and intensity of this process and its intensity required pacing and time for consolidation, along with supportive interventions. In order to progress, participants needed space, time, and emotional support from the therapist. There were different ways in which this notion of progression was expressed. Some participants recognized this stage as still very distressing, mainly due to the difficulties arising from getting in touch with deeper emotions. Others spoke about exploring the reasons behind specific behaviours and trying to “move beyond” symptomatic expression of the problem. Some participants acknowledged becoming “more free”, as they were less restricted by the external or situational manifestations of their problems. Others referred to this as a “stage of self-reflection”, “a period of exploration”, a “confessional phase”, and “a much more directed and focused period of self-reflection and self-contemplation”.

Delving deeper often had an effect of raising more material and as one participant put it, “it seemed like suddenly, these floodgates opened; there were things that I really wanted to talk about that I had never talked about with anyone before”.

Some participants referred to this process as “stripping away layers of an onion” where material worked through on one level frees space for a deeper level material to emerge. Overall, this stage was characterized by intense work on deeper psychological levels, which appeared to promote more sustained change. In this stage, there was a growing realization that lasting change required sufficient working through issues, often on a very deep level.

Another participant expressed the essence of the transition from the beginning into the middle stage:

After those first couple of sessions, where it started to get a bit more difficult in terms that I had to work harder to work through the issues, it wasn't so like, 'Oh wow!' And insight makes you feel better, 'Hang on, I am still actually getting controlled by these issues and getting controlled by the emotions that are related to it', so I actually had to delve a bit deeper, 'What is happening for me?' So, yeah, you sort of went from a high of, 'Oh wow! That's fantastic' to not a low, but a, 'Oh hang on, it is not as easy as I thought it was going to be. It is not as immediate as I thought it was going to be.'

The significant challenge here was in maintaining motivation and hope in the face of slow modulation and incorporation of new insights into a more stable structure. This process of fluctuation between progress and regression appeared to be coloured by fragility and frustration. In many instances, progress and intensification of psychological work activated resistance. In some cases, increasing the frequency of sessions allowed resistance to be overcome through deepening therapy. The dynamic was given expression through the struggle between different parts of self that stood for opposite tendencies:

In the middle it kind of gets worse. It tends to get worse, I think, when you kind of realize just how fucked up you are, but that is happening. That might be conscious but then there is this unconscious part of you that also thinks that it is not really worthwhile, which is probably because you are actually touching on important issues. I remember there being part of me with that thought, 'Oh, I don't need therapy after all. I am just being a sook.' It was kind of wanky and, yeah, it is self-indulgent. Quite often, I would forget my appointments. It is probably actually about touching on some more interesting stuff or going through feelings of being unworthy of therapy, which was probably the best part of the therapy really, in terms of the realization about that.

In other cases, progression to the stage of deeper psychological work evoked intense feelings of exclusiveness and non-reciprocity. One participant described herself as “very self-centred”, and added “I don't want to know that you have got a life outside this room. You belong in this room and that's it”. This need for having the therapist exclusively to oneself and intolerance of any outside intrusions,

including the therapist's own disclosures, is indicative of strongly operating developmental processes; early attachment dynamics were reactivated within the therapeutic dyad and the client wanted the therapist all to herself, just like a child requires this form of exclusivity from the mother (Hurry, 1998). Another significant aspect of this stage of treatment was the idealization of the therapist. This also points to a developmental dimension strongly operating in the stages of deeper and more intense psychological work. Attachment theory provides a framework for understanding both developmental and interactive processes operating within the therapeutic dyad (Holmes, 2011). The therapeutic relationship typically revives early attachments, along with unresolved conflicts and traumas (Hobson, 2004; Hurry, 1998). As illustrated above, the stage of deep psychological work activated the client's early attachment needs, which are reflected by the need for the therapist's transition from being a helpful professional to the role of indispensable attachment figure (Hurry, 1998). Hurry further explains that these old patterns of being and relating, when reactivated in the safety of the therapeutic relationship, have the power to potentiate arrested and inhibited mental processes. This is in line with research and theory (Fonagy & Target, 2007; Hurry, 1998; Pine, 1994; Schore, 2011) emphasizing the growth-facilitating function of the therapeutic relationship and understanding the developmental function as central to the therapy process.

**Testing newly acquired insights.** Typically, this stage was characterized by putting understandings developed in the course of treatment into practice. Participants spoke about developing enough strength to begin testing their knowledge outside of the therapy session. During this phase of treatment, the therapist's support appeared to be crucial. Participants referred to this stage as "a phase of application", "trying out new ways of thinking and responding", and "having some tools but using them quite inexpertly". The process of testing newly acquired insights typically followed the sequence of developing strategies, rehearsing them in the session, and putting them into practice outside of the therapy room. Participants described this stage as having an "experimental mindset", "changing unhelpful patterns", "stretching a little bit", "trying out different world views", and "internally and externally running experiments". At the same time participants reported experiencing fluctuation in levels of confidence regarding applying newly developed skills. The process of undergoing changes was accompanied by a significant amount of fear; in order for this to be worked through,

the stable and supportive presence of the therapist was needed. As some participants were facing the fear of what was going on for them, they found it helpful for the therapist to listen and let them be “talked through” what they needed to do. Others emphasized the importance of being able to remain open to and trust the therapist’s suggestions in the first place:

So it is being able to listen for that therapeutic message and then to be able to anticipate that message. So, first of all when I first heard the suggestions they were novel and sometimes even sort of a bit simple or whatever, but then you sort of sometimes anticipate them. And a lot of it was reporting back on using the strategies and how they worked.

This excerpt also illustrates the process of internalization of newly developed ways of thinking and problem solving, which were promoted by the therapist’s mode of inquiry into the client’s problems. This was also a period in which participants attempted to generalize newly acquired insights across various areas of their lives. While this stage was predominantly about application, participants often mentioned the need for the therapist’s guidance, support, suggestions, and in some cases even permission to try new behaviours. Over time, application of new strategies expanded to a greater variety of contexts in clients’ lives.

The acquisition and the application of new understandings, as illustrated by these excerpts, are congruent with theory and practice of the cognitive-behavioural tradition (Castonguay & Hill, 2007). A cognitive-behavioural perspective views problem behaviours as consisting of cognitive, affective, behavioural, and physiological elements. It posits that change can be fostered through learning new skills and engaging in experiences that challenge and correct old maladaptive patterns (Dobson & Dozois, 2010). The therapist’s role, as understood within this framework, is more that of a coach who helps identify the areas requiring new skills and actively facilitates the learning process, as well as the client’s sense of efficacy (Dobson & Dozois, 2010). This is reflected in participants’ preference for the therapists’ active engagement at this stage of treatment. The cognitive-behavioural principles of exposure also provide a useful framework for understanding participants’ progression from developing strategies, rehearsing them in the session, and putting them into practice outside of the therapy room. Participants typically engaged in the process of exposure to new experiences which, in line with cognitive-behavioural theory, facilitates the unlearning of old patterns and learning new ones. This notion has been supported by a large amount of research indicating that psychological

insight alone is not sufficient for change to occur and that learning through experiencing is necessary (Bohart, 2000; Castonguay & Hill, 2007).

**Experiencing gradual improvement.** This theme captures participants' recognition of improvements that found expression both internally and externally. Nearly half of participants spoke about experiencing a gradual sense of improvement. This consisted of feeling better and being able to enjoy life. One participant stated "I started to come out a little bit of the hole and could see the light". Some described themselves as being more aware of themselves and their surroundings. Noticing progress had a self-encouraging effect, but participants also needed the therapist's encouragement and motivation in sustaining the efforts:

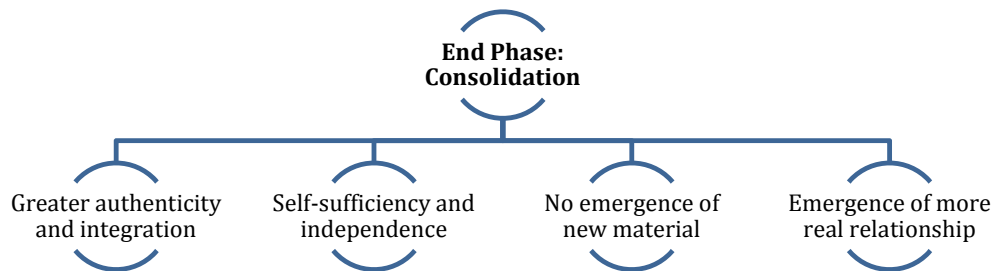
I felt very positive that I was making progress. And he would say, 'You really are making progress' and I would say, 'Really?' and he would say, 'Yes, you are.' And I knew he wasn't just saying that to make me feel good. So that really is encouraging, even though you are still going through issues, you can just see little improvements and feeling better every day, so you had that positive attitude to keep going as opposed to thinking, 'Oh I'm okay now; I'll stop.' You knew it had to go on. So, yeah, I felt confident and positive.

This process of overcoming difficulties required a shared medium of communication. It needed to be reflected by the therapist, but also further promoted by his or her understanding of the nature of the process of change. Having an awareness of the stages and accompanying emotional states likely to be experienced by clients provides therapists with a structure for new developments. In terms of changes in thoughts and attitudes, for some participants there was a sense of greater acceptance and understanding of oneself and others, in the context of experienced and acknowledged improvements. Some of the statements used to describe self at this stage included "feeling okay in myself for probably the first time", "becoming aware, and waking up", and "had a better feeling about myself". Similarly, in other studies participants reported a sense of a new beginning or a return to their normal way of life (Carey et al., 2007).

### **End Phase: Consolidation**

The final cluster of themes relates to the views and perspectives of participants concerning the end phase of therapy. These included four subthemes: 'greater authenticity and integration', 'self-sufficiency and independence', 'no emergence of new material', and 'emergence of a more real relationship'. Characteristic to this stage was the experiencing of greater authenticity and self-

sufficiency. The newly acquired insights had been integrated into the personality structure. This led to participants experiencing themselves as more integrated.



*Figure 9.* End Phase: Consolidation.

**Greater authenticity and integration.** One of the facets of consolidation that gave a more coherent and harmonious experience of self was an increase in authenticity and self-integration. This process was also characterized by an assimilation of new insights into the personality structure. One of the ways this manifested was through a sense of being “calmer”, “happier”, and “more present”. This finding is consistent with other studies focusing on the clients’ experience of change in therapy, in which participants described changes in their emotional states as undergoing transformation from depression, anger, guilt, and feeling miserable to being happier, calmer, more tolerant and relaxed (Carey et al., 2007; Higginson & Mansell, 2008). Some participants described this sense of being “finally complete and stronger” as a result of having done a “full circle”. This experience of having worked through issues fully was regarded as an indication of treatment being completed.

Authenticity expressed itself through greater acceptance of different parts of self as well as acceptance of experiencing difficulties as part of life. This represented a more mature and realistic outlook on oneself and the world. Some of the ways in which participants described this included “realizing that I am just a myriad of different qualities”, “integrationist sense of self, the mundane and the occasionally exceptional, and just more of a general self-love”, and “just accepting more myself,

and being able to put things in perspective”. As can be seen from these statements one of the main outcomes of developing a sense of authenticity and integration was the feeling of being more complete and at ease with oneself. Another consequence of greater authenticity and integration was a transition from being attached to, to being in a relation to, self and others:

And now, a lot less distressed, better relationships and also a sense that I feel quite comfortable in myself and less like I need the love and support. And, like, sometimes I am better off in my own space than having someone else’s input, so I guess less needing of what therapy offers. Yeah, less needing of her input and, I guess, the love and the support that I get from her but probably I guess, yeah, there is an element of that in other relationships as well.

Participants often spoke about experiencing themselves in more accepting and positive ways. This self-appraisal took on various expressions, from concrete to abstract. For example, “I might have been a four at the beginning, in the middle I was probably feeling more like a three, and then towards the end I was probably feeling more like a six. I could see a marked change in myself”, or “I suppose it has made me a more rounded individual”. Of significance in the first statement is the fact that this participant felt worst in middle stages of therapy than at the beginning. The middle phase was typically characterized by intense, deeper-level work, and therefore led to greater discomfort than the initial phase of treatment. Participants in the study by Carey et al. (2007) also report attitudinal changes. Acceptance was one of the main changes, in that they were able to accept something that was unrecognized or resisted before. In this current study, acceptance manifested itself through the recognition of one’s own limitations and assimilation of positive and negative aspects of self.

These newly acquired insights were also, at this stage, integrated into a more stable psychological structure. This involved creating new connections between thoughts and feelings. Participants described themselves as “feeling present”, “taking more risks”, “bringing together the intellectual and the emotional”, “bringing together the past and the present”, and “more generally applying what I have learned already to my life”. This process of integration was facilitated by a greater emotional stability that provided sufficient space for information to be processed and in turn consolidated.

Another significant characteristic that emerged at this stage was the ability to look at oneself and the world through a wider lens. Participants described this as



having "a widened perspective", "a bigger picture", "really opened up", "the flexibility that comes with having this experience", and the ability to "stay broad and not get caught up in that mind stuff". Finally, integration took on a more professional aspect for participants who were therapists themselves. They were able to consolidate the knowledge and experience of being a client into their professional and personal disposition.

**Self-sufficiency and independence.** This theme reflected the participants' self-assessed levels of strength and skill at the end of treatment. Typically, participants recognized experiencing greater psychological strengths towards the end of therapy. This was expressed through the changes in behaviour. Some of these were significant, as they concerned actions central to the participant's difficulties such as perceiving themselves as more independent of their therapists and being self-sufficient in addressing their own issues. Behavioural changes were also recognized, such as having greater motivation and determination to deal with problems, which was most likely maintained by a sense of satisfaction and capability. Some of the common ways in which participants described themselves at this stage included "self-sufficient", "resilient", "being able to handle it myself" and feeling a "sense of completion". One participant put this in the following way:

I am in really quite a good place. I mean, I feel quite okay that no matter what life throws at you, yeah, some things are going to be really upsetting and emotionally painful to deal with, but I will be okay. I think the therapy has given me the skills to do that.

Analogous to outcomes reported by Higginson and Mansell (2008), participants in the current study also reported the enhancement of relationships and changes in self and world view. They typically described themselves at this stage of treatment as "being more in control", "being able to better manage problems", "feeling stronger", "being more assertive, confident and insightful", and having "levels of distress reduced". This strength also manifested itself by the ability to reflect on things, better control of both thoughts and feelings, and application of skills learned in therapy. It is important to point out that higher levels of self-sufficiency and independence did not preclude participants from recognizing weaknesses and seeking help when needed. A greater ability to accurately self-evaluate also promoted a more realistic view of oneself in relation to others. Statements such as "seeing things for what they were", "therapy never took me to a point of optimism",

and “I’m more settled on my limits and the limits of other people” give the impression of mature realism, but also self-acceptance.

While a sense of independence predominated this stage, participants recognized the importance of knowing that if they needed support they could rely on their therapists. This knowledge seemed to provide a sufficient level of strength in itself, for example: “I can handle this because I know I’ve got her there”, “I do like to know that she is there if something went wrong”, and feeling “content that I had somewhere to go back to if things changed”. These statements could be seen within attachment theory as reflective of the developmental stage of exploration and mastery (Holmes, 2011). The mother–infant literature suggests that this dimension of ‘mastery’ also communicates the presence of a competent adult in charge of the play-space and provides a ‘defensible space’, which guarantees security (Holmes, 2011). Similarly, as illustrated in the above excerpts, the therapist provides this space, physical and metaphorical, in which the client can safely explore and master new skills.

Along with the sense of satisfaction and accomplishment, some participants began perceiving therapy in an open-ended sense:

Well, for me, there is never a closure. Self-development is a lifelong process, so I guess I would say the final stage in my time in therapy, this round, would be I guess more efficient, and efficiency in emotional reactions, in choices of behaviour, and ability in the way I think through problems and issues.

Likewise, participants in other studies indicated that while significant changes have occurred, they recognized the potential and need for further work (Care et al., 2007; Higginson & Mansell, 2008; Perren, Godfrey, & Rowland, 2009), suggesting that there is an ongoing dimension to the process of change. This indicates that the therapeutic process can continue after formal psychotherapy has ended. It could be hypothesized that specific psychological formation, once established in psychotherapy, continues operating within the self. Such propensity for self-therapy provides a way of being in contact with oneself and enables gaining new awareness subsequent to formal psychotherapy.

**No emergence of new material.** This theme speaks to participants’ experience of the ending of therapy. Some participants acknowledged the awareness of approaching an end when they began to make a deliberate effort to find new material for discussion. It seemed that for some, this was a clear indication that therapy was coming to an end, whereas for others, therapy took on more of a

maintenance form. This sense of greater independence and self-reliance appeared to be in proportion to decreasing emergence of new material. Participants at this stage often spoke about “looking for things to talk about” or even “inventing things to talk about”. In some instances the sessions were getting shorter; in other cases they were scheduled more sparingly and began functioning in a maintenance form:

I knew we were coming to an end because I would be driving to therapy and I thought, ‘I wonder what I need to talk about today’ you know, and ‘Is this something that I should still be doing?’

As participants became more self-reliant, these late stages of therapy began taking on more of a maintenance function: “it would be more day-to-day stuff”; doing it on “ad-hoc basis”; and the “process of dealing with everyday issues ... gradually it started becoming almost like a physical exercise where you kind of replenish your body’s strength when you exercise your body”. For some participants, maintenance progressed to a natural ending, “the end bit was just tying up some loose ends, so to speak. So by the time I finished, I was ready to finish. There wasn’t really anything left”. For others, it remained in the form of infrequent but ongoing support, “and now I see him every month, mainly because I don’t want to break all the ties because it has been so good”. This participant describes the maintenance function well:

Well, it is 50 minutes out of a month or a month and a half, so it is a check-in, and possibly a comfort thing as well, because now it is a relationship where she had known a lot about me for a number of years and so serves as an adjunct to my own sort of early warning systems, I guess. It is not really it; it is more relationship maintaining now, I would say, which possibly should change but I think we both are happy enough with it now. But, yeah, the actual work I would say finished quite a while ago.

These excerpts point to the significance, not only of ongoing support, but also the need to maintain a close relationship with the therapist even after the main therapeutic work has been finalized.

**Emergence of more real relationship.** The end of therapy was characterized by qualitative changes in the therapeutic relationship in that a more real relationship emerged. Participants spoke about a shift in the nature of the relationship, as this became more reciprocal interaction. This took on various forms. One example of this change in dynamic is illustrated by the way the client and therapist approached the last session:

I remember the last time I went to see her, you know it was funny, I felt like I wanted to thank her and I didn’t need her and it was like saying goodbye to your mother because you don’t need her anymore. It was all good, and I brought her some

grapes from the Swan Valley and risking that you are not meant to give your therapist a gift, however, just risking it because it was a food item. And she received it and that was good, and I guess I was very uplifted. Yeah, I remember that. Yeah, I just still remember that there was a lot of laughter and lightness at the end but I didn't know it was the end as such.

Change in the relationship also took on an expression of the therapist showing more curiosity about the client's circumstances that had no immediate relevance to the therapeutic work. This was typically experienced as positive. In some instances, however, by contrast, it brought the awareness of that which was missing in the therapeutic relationship:

I think it was only the last session where I felt it was a little bit more connection, but it was sort of the last session that she was enquiring about my studies, but it was near the end that I felt there was a bit more connection.

For others, this change in the relationship became more of a gradual development that spanned over a few sessions. Participants typically described it in terms of an emergence of a more personal connection that went beyond a strictly therapeutic relevance. This is illustrated in the following excerpts:

And then even sort of the ending bit, those last couple of months, it had a different feel. I found out little bits of personal information about the therapist.

The therapeutic relationship is described as having undergone changes which were often described in terms of becoming "more natural" and "more personal":

Yes, I might have a romantic view of it now, but it is like a true friendship thing that stays, so I don't have any regrets; no I don't.

I suppose from my side it felt like she actually really liked me as a person, not just as a money maker. It wasn't a performance. She was being very real, and I think it was a real relationship that was ending, and it was hard for her as well as me, and I think that came across, that realness of it.

This introduction of personal disclosure towards the end led to the transformation of a therapeutic relationship into a more real relationship. This enabled participants to transition out of this stage of treatment. There was a sense of feeling more equal with the therapist, which potentially also played a mitigating role in the terminating phase. At this point in treatment, participants appreciated the therapist's personal disclosures, unlike in the middle stages of treatment when this caused significant distress. The analysis indicates that in the beginning phase, where trust needed to be established, participants expressed curiosity about the therapist's professional and sometimes personal credentials; in the middle phase, where deeper level work took place, participants developed intolerance for the therapist's self-

disclosure and in some cases even experienced it as intrusive; and in the final stage of treatment, there was a greater need and acceptance of this level of interaction.

This study explored what clients' descriptions of change might be without using a predetermined taxonomy or set of stages of change. It is notable that all participants described change occurring as a gradual process and, at the same time, as broadly identifiable stages, which are qualitatively distinct points along the continuum. Participants provided information about the content of the change, in terms of what had changed for them, as well as the process of the change, that is, how these changes came about. Furthermore, unequivocal quantification of the change from negative to positive experiences was reported. This is consistent with numerous studies (Carey et al., 2007; Higginson & Mansell, 2008; Perren et al, 2009).

General characteristics of the beginning, middle, and end of treatment stages, map well onto previous research on different stages of therapy. For example, a study conducted by Holmes and Kivlighan (2000) showed that the 'relationship-climate' component was higher at the beginning and at the end of therapy, whereas 'insight and client growth' events were more prevalent in the middle stages of therapy. Cummings, Hallberg, and Slemon (1994), in their investigation of the templates of client change in short-term counselling, discovered that 'hope events' decreased while 'cathartic events' increased in frequency over time. One of the logical explanations for these findings, also reinforced by the current data, is that the clients first need to feel psychologically safe (e.g., 'building trust') for any deeper therapeutic work to occur (e.g., 'progression from surface to deeper levels'), and subsequently preparing for the end of their relationship with the therapist (e.g., 'emergence of a more real relationship'). In broader terms, these findings are in agreement with the trajectory described by participants in the current research of moving from the surface to the deeper levels of work, as the relationship between the client and the therapist strengthened.

This chapter focused on explorations concerned with participants' experience of the stages of change. When asked to reflect on stages of therapy, participants recognized, above all, a gradual progression unmarked by obvious points of transition. Their descriptions, however, allowed for distinguishing characteristics specific to the beginning, middle, and end phases of therapy. There was a general consensus that in the early stages of therapy the experience was one of emotional

disorganization and varying levels of distress. Subsequent to establishing solid trust, the transition from symptomatic to structural change began. In this middle phase progression from surface to deeper levels generated gradual improvement. Late stages of therapy were described as having a consolidating effect, in that they were bringing about a greater sense of self-integration and authenticity, as well as self-sufficiency and independence.

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## **CHAPTER Five**

### **Problem Formation and Resolution**

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This chapter summarizes findings on the clients' understanding of the origins of their difficulties and the ways of addressing them. Three main themes emerged in this domain: problem formation and resolution; allegiance and expectancy of the treatment model, therapist, and therapeutic environment; and client agency. The first theme related to the participants' thoughts, feelings, and beliefs about the origins and possible solutions to their problems as understood at the commencement of therapy. While initially having some general sense of problem formation and resolution, participants commonly reported that it was the understanding developed in therapy that promoted change. Along with having a general understanding of problem formation, participants had some insight as to what was required for the change to occur. This was further explicated in the theme of allegiance and expectancy. Having preference for a particular form of therapeutic intervention, when complemented by a desirable therapist's qualities, led to positive changes. The third theme explored ways in which clients express agency within therapy sessions and externally. Specifically, it focused on the ways in which clients use psychotherapy to change, how they communicate disagreements and disappointments experienced in therapy, and the level, nature, and reasons for concealments from their therapists. Table 9 provides a summary of the type and frequency of superordinate and emergent themes for this domain.

Table 10. *Problem Formation and Resolution: Frequency of Occurrence of the Theme*

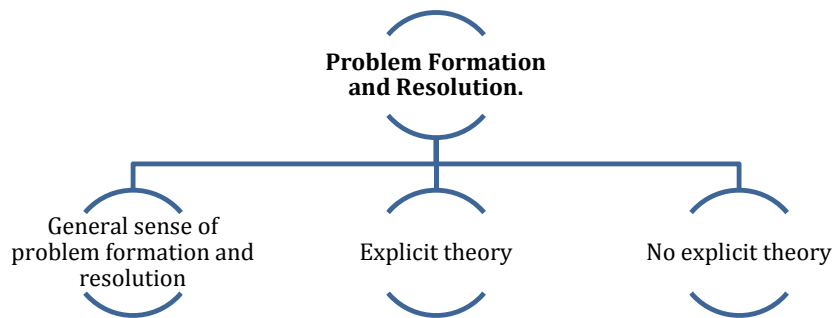
<b>Problem formation and resolution</b>	<b><i>General</i></b>
General sense of problem formation and resolution	<i>Typical</i>
Explicit theory	<i>Variant</i>
No explicit theory	<i>Variant</i>
<b>Allegiance and Expectancy</b>	<b><i>Typical</i></b>
Client's allegiance to treatment model	<i>Typical</i>
Preference for type of therapist	<i>Typical</i>
<b>Client Agency</b>	<b><i>General</i></b>
Openness with therapist	<i>General</i>
Applications in life	<i>General</i>

General: all cases or all but 1; Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

### **Problem Formation and Resolution**

This theme relates to the thoughts, feelings, and beliefs of the participants about the origins and possible solutions to their problems as understood at the commencement of therapy, and includes three emergent themes, 'general sense of problem formation and resolution', 'explicit theory', and 'no explicit theory'. The client's explanations about the presenting problem, its causes, and potential remedies has been discussed by Duncan et al. (2010) as a fourth ingredient of the therapeutic alliance, following shared goals, consensus on task of treatment, and an emotional bond. Their research shows (e.g., Duncan, Miller, & Sparks, 2004; Hubble et al., 1999), that the strength of the therapeutic relationship, length of treatment, and rate of success is positively correlated with congruence between a client's beliefs about the causes of the problem and the treatment approach. Therefore, this study in exploring clients own understanding of problem formation and resolution aims to further our understanding of constituents of positive change.





*Figure 10.* Problem Formation and Resolution.

**General sense of problem formation and resolution.** Typically, participants reported having a general understanding of the causes of their problem. This was expressed in ways such as, “there were some sorts of family of origin issues, so there was that general desire to work on that area”. Some participants spoke about a “surface”, “sterile”, and “cognitive” level of understanding. The general sense of problem formation was also described in terms of an “approximate” understanding that needed further development: “I was aware of what was the approximate cause of my depression, and in part that was what therapy was for me, honing my informative and my informed guesses, I feel like it was fleshed out in a lot of ways”. The development of a more in-depth understanding was described as the process of “going deeper” and “gaining clarity”. Analogous to other research (Gavrilovic, Schutzwahl, Fazel, & Priebe, 2005; McLeod, 2012; Nilsson, Svensson, Sandell, & Clinton, 2007), participants in this study reported that it was the understanding developed in therapy of how certain issues were contributing to and maintaining their current difficulties that promoted change.

They also had a general understanding about what was required for change to occur. One participant described this in the following way:

I suppose on that surface level, I might have had more of an idea of what was going to help and I might have had some theoretical understanding of what might have helped, but I don’t think that I really knew.

This notion of having some degree of an intellectual understanding while at the same time ‘not really knowing’ was further expressed by another participant for whom deeper reasons for seeking treatment were only available implicitly:

I kind of was seeking reflective functioning, but perhaps I didn’t know I was seeking....  
I guess a lot of what I think therapy - - I mean partly you are learning about what you

don't know that you don't know, but you are also learning about what you know that you don't know that you know, and that is about early non-verbal experience. So I guess I was kind of seeking that although maybe I didn't know I was seeking that, is perhaps the best answer I can give to that.

These participants describe the experience where this which is yet unknown or unformed, not yet consciously conceived, is transformed through the process of therapy into something more explainable and visible. For example, in contemporary psychoanalytic literature this experience of 'knowing', has various terms, including 'unformulated experience' (Stern, 2002), 'pre-reflective unconscious' (Stolorow & Atwood, 1992), 'the unthought known' (Bollas, 1987), and 'implicit relational knowing' (BCPSG, 2010). It is the interaction between the therapist and the client that allows for these implicit, preverbal, and pre-reflective experiences to be transformed into explicit, declarative, and dialogic experiences (Beebe & Lachmann, 2005). Analytic literature describes this process of 'coming to know' as emerging and being co-created within the therapeutic dyad (Beebe & Lachmann, 2005). According to attachment theorists and researchers it is the therapist's capacity to mentalize the client's experiences in the way that brings them into a "full body/mind experience" (Harris, 2009, pp. 11–12).

All participants considered therapy as a prerequisite for change and all perceived therapy as conducive to resolving their problems. Even those who thought that issues could be resolved with time believed therapy to be a medium that accelerated this process and brought qualitatively more helpful solutions. This is consistent with research indicating that a client's hope and expectancy is one of the factors necessary for therapeutic change (Lambert, 2005). Echoing research on therapeutic factors, participants in this study stressed the centrality of the therapist's role in helping them make sense of their experiences, a notion that has been confirmed by a plethora of studies (i.e., Blatt, Zuroff, Hawley, & Auerbach, 2010; Gelso & Carter, 1994; McLeod, 2012; Norcross, 2002; Safran & Muran, 2000):

I wouldn't have been able to do it on my own. I mean, you can read all the books that you like, ..., and you read them but they are quite general. You just need someone to really look at you and look at your behaviours from the past and look at your upbringing and your relationship with your parents and that kind of thing and look at why.

Others were able to identify a preferred mode of treatment that could bring about some resolution, for example, "there was a general sense that I wanted to work with the unconscious and that would help me". There were also some more general

composites not confined to the therapy setting, such as “active talking, whether in therapy or not in therapy, has always been a way that I make sense of things”; “finding time for myself”; and “my own experience of being in the world”. Some participants knew what their ultimate treatment goal was, but needed assistance in achieving it: “I knew that accepting myself as I am is the ultimate goal.... and therapy shows different doorways into the possibility of it”. Finally, for some participants it was an issue of finding the type of therapeutic environment conducive to developing and finding one’s own answers, as opposed to having an explicit theory of what may help:

I knew the sort of thing I needed. I knew the sort of thing to go to, not the person I was looking for, but the sort of thing I needed. I didn’t know the solution or the possible solution, but - -Yes, what environment I needed and what type of person I needed to help me with it.

**Explicit theory.** Less than half of participants had a more explicit explanation of problem causation, some of which focused on specific events, while other considered a broader underlying mechanism responsible for maintaining their difficulties. Commonly, initial understanding of the origins of the problem evolved and changed as the therapy progressed. For these who initially viewed the problem as external to themselves, their theory changed with therapy to include internal as well as external components. In some instances, however, participants’ explanations did not change as a consequence of therapy, but the mode of experiencing and responding to self and others did change: “My own explanation didn’t change, but my ability to experience my life changed”. In some cases the issues which originally brought participants into therapy did not remain the focus of the treatment: “my reasons for going probably, yeah, were not what I ended up needing to look at and to work on”.

In some instances, there was recognition that having a theory of problem causation did not facilitate the process of resolution as such understanding was not sufficient: “I felt like I had really good theories but that they didn’t make a difference. I might understand why I felt the way I did, but being able to do something about it is kind of the challenge”. These explanations, while in retrospect not necessarily adequate, often served as a “springboard” to exploration, or as one participant stated, “my own theories were helpful in that I re-examined them and realized that they weren’t working as models of thought”. Theories, even if inaccurate, in the early stages provided validation for the client’s own competence

and credibility, as well as a starting point and solid foundation to begin therapeutic work. One therapist–participant stated that having an initial problem formulation played a facilitative role in establishing therapeutic alliance. In this case, not the explanation in itself, but the rapport it generated between the client and the therapist was change promoting.

Some participants also reported having a clear idea of what would assist in the resolution of their problems. These were often aspects external to themselves, concerned with circumstantial or relational changes. Such concepts were typically abandoned during the process of therapy and replaced with more internally focused explorations. The extract below serves to illustrate the transition from avoidance to exploration:

My perspective was that if you had a problem, then you put it in a bag, you dig a hole and then you bury it and you move on. That was the way I looked at dealing with stuff, you know.... But it doesn't work that way, because no matter how deep the hole it is still there.... So that sort of theory went out the door.

When reflecting on two different therapeutic encounters, one participant recognized that his beliefs about the nature of change played a very significant role in his process of recovery:

I think that was helpful because I suppose you can't help what has happened. You can only help what is ahead of you and I think that is what he was helpful with. The other person was more about what had been before and why that has possibly impacted on the way I am now, which is fine, but it doesn't help me. But he was more, 'So, what is happening now? And where do you want to go from here?' So he was able to, not direct me or anything, but help me see that there was a path which I could take and it could make a difference to where I was going to go.

In some cases therapy provided verification and consolidation to the participant's theory of problem resolution: "therapy enabled me to consolidate those ideas and take more meaningful action in accordance [with] those ideas". Some of these theories were concerned with the mechanisms underlying the process of change. According to one participant, gradual change with small steps was what was required to produce long lasting and deeper change; understanding was derived through many failed attempts at achieving a longer-term solution to his problems. Another explicit theory addressing the process of problem resolution was provided by a psychologist–participant:

That is a question that I think about a lot as well, even with others. My own theory is emotions are not something you overcome, like the mountains there. You don't really walk them, you actually go through it. And there is wisdom involved in it because it is a lived experience. I think it is not so much as people always say,

‘Experience counts in life.’ I think it is not just that. I think it is what you do about your experience in life. It is the experiencing, you know, you are living it, going through it. And I felt the fact that I was able to go through it without trying to have coping skills to deal with it, meditate, or blurt it out. Going through it, there was a lot of wisdom, because these sorts of emotions are like an alarm that goes off. And the alarm that goes off, we take it as a signal and we run, ‘This is a fire.’ Instead of that, sometimes I think we try and just shut the alarm up. But what if there is really a fire? So, to me emotions are like signals, I guess. And it is a felt signal. It is not just a known signal. You have to sense it from the affect level, I guess. And by talking in that way, it gets provoked in that experiential way and you have to save it, you have to process that, and yet new meaning forms out from that. I don’t know how, but somehow if you go through it and you stay with it, new meaning comes out from there.

This explicit theory reflects the ‘experience-near’ form of insight in which change occurs as a result of a felt experience (Greenberg, 2002; Pascual-Leone, 2002; Pascual-Leone & Irwin, 1998) According to these theorists insight develops in two dimensions, abstraction and the type of processing which determines the form of insight as either experience-near or experience-distant. The description offered by this participant reflects the process of change as occurring on the lower levels of abstraction where perceptual-emotional processing characterized by concrete experiential content dominates over a conceptual-rational form of understanding (Greenberg, 2002).

**No explicit theory.** Less than half of participants reported having no understanding of the causes of their problem at the beginning of therapy. Some had various reasons for seeking help but did not have a coherent understanding of what was causing their problems: “I didn’t really understand it”, and “I had lots of reasons. I didn’t understand any of it until I went to therapy. I didn’t understand the reasons I tried to commit suicide or hurt myself in any way. I didn’t understand any of that”. Despite substantial efforts on their part, for some participants no convincing explanation was established prior to seeking help: “I thought long and hard and analysed too much of everything, but I couldn’t tell you”. In these cases the impetus for therapy was precisely that of finding an explanation of the predicament faced; as one participant stated: “it wasn’t until I went into therapy that I had some other explanation that sat with me, yeah, that made sense”.

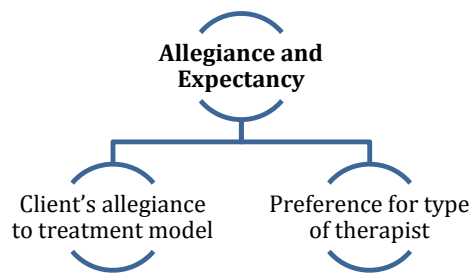
Apart from needing assistance in overcoming difficulties, some participants acknowledged having no clear concept of how to address their problems: “I went into therapy because I didn’t know the way out”; and “ninety-five per cent [not knowing], because at the time I really had no idea of how to deal with anything I was

going through”. This notion is consistent with other studies (Bohart & Tallman, 1999). The lack of an explicit theory of problem resolution was equally prevalent amongst participants who were therapists and non-therapists surprisingly. This is illustrated by some of the extracts from therapist–participants: “initially I wanted help but I didn’t really know what that would look like or what I needed”; “I just knew that I didn’t like how I was reacting and I didn’t want to keep on doing things the same way”; and “the situation I was facing seemed so intractable that at the time I couldn’t see how I was going to view this situation differently”. Still for others, the need for resolution was paired with the desire for a magic cure, “I was looking for someone with the magic answer. I knew it would get better. I just didn’t know how”. A significant body of research places client expectancy and hope amongst main factors accounting for change (i.e., Arnkoff, Glass, & Shapiro, 2002).

Participants showed considerable variation in their articulations of pre-treatment etiological formulations and resolutions, ranging from very distinct ideas to very vague presuppositions. Pre-treatment understanding of problem formation was more common amongst therapist–participants. This ability to articulate etiological formulations is mostly likely a result of having greater psychological knowledge in comparison to non-therapist participants.

### **Allegiance and Expectancy**

Participants typically reported having a preference for the type of therapy as well as therapist and therapeutic environment. In order to achieve an optimal treatment outcome these three factors needed to be present to a satisfying degree. Having an intellectual allegiance and curiosity in relation to a particular therapeutic framework, when complemented by a preferred therapist, and a conducive therapeutic environment, led to positive changes. Research confirms the client’s ratings of these factors as the strongest prediction for positive outcome in therapy (Ahn & Wampold, 2001; Safran & Muran, 2000).



*Figure 11.* Allegiance and Expectancy.

**Client's allegiance to treatment model.** Participants typically expressed some degree of preference for the model of treatment. Therapist-participants were more cognizant of the type of treatment they would likely benefit from, whereas non-therapist-participants relied more on an implicit and intuitive understanding of what could help them. Therapist-participants more frequently than non-therapists provided a clear rationale for treatment preferences. One therapist-participant described the importance of the client's and the therapist's allegiance to the same treatment model in the following way:

I would classify myself as psychodynamic, coming from an object relations theoretical orientation, so there was certainly a match. I sought out someone, because that was what I was interested in .... I think there was a convergence in most of the issues, like an interest in the unconscious aspects, like the transference and counter-transference.

However, that same participant indicated that even a very strong allegiance to a treatment model does not eliminate doubting its effectiveness. She described going through phases filled with hesitation as to the helpfulness of the chosen method: “‘Is this working?’ because it felt a bit like sand running through your fingers ... it was scepticism around - am I doing the right thing?” This points to the issue of sustainability of motivation in instances where the client's allegiance to the treatment model is not very strong; it could be assumed that weaker allegiance could significantly impair the client's ability to work through the more difficult and challenging periods of treatment.

In the process of choosing forms of therapy, non-therapist-participants often sought information and advice from psychologist friends. They had a very good sense of what was needed and were proactive in making their decision about the type of therapy:

Interestingly, my doctor was like, ‘I think you need some CBT’ because that is what they give you. And so I kind of went down thinking, ‘Oh, I need CBT’ but it didn’t feel right. To me, I can have all the strategies in the world, but when I am at full flight on one of my anxious episodes they are not going to help me .... I was a bit iffy about it, so I spoke to a few people that know counsellors and psychs. I sort of wanted someone who had the scope to go beyond CBT. So, I knew that CBT would perhaps be useful to a certain extent, but I needed something deeper. I needed something that was going to go a little further than just give me strategies and processes and stuff like that. I needed some nasty work.

One participant provided an insight into what it meant to have no allegiance to the treatment model and what it entailed to work on the presenting issues under such circumstances:

The idea of what I thought would be helpful meant that idea congruent therapy suggestions were easier to act upon and I was more instantly motivated to work through them, so it made me more accepting of certain therapeutic interventions or discussions ...and meant that I required more convincing if it was my idea incongruent. I did most of the things that were outside of my pre-existing ideas. No, in fact, I did all of the things that were outside that were suggested. It just meant there was a longer discussion before getting to that point. I needed to be convinced of it.

Findings from the current study appear compatible with a substantial body of research on the impact the client treatment expectations and preferences have on the outcome and process of therapy (Arnkoff et al., 2002; Greenberg, Constantino, & Bruce, 2006; McLeod, 2012; Swift & Callahan, 2009). Overall, research indicates that the fulfilment of client preferences is a significant determinant as to whether a client will stay in therapy, and on the outcome of therapy. Swift and Cullahan’s review of 26 controlled studies showed that clients who received a preferred therapy had 50% fewer premature dropout rates and reported substantially more beneficial outcomes at the end of therapy. A study by Handelzalts and Keinan (2010) further showed that clients who believed they had chosen the preferred model of treatment reported significantly more improvement than the control group, which also received preferred therapy but was made unaware of this.

**Preference for type of therapist.** Typically, participants reported preferential characteristics of the therapist they wished to engage in therapy with. These often included the therapist’s ability to make them feel safe and accepted. Other characteristics that were valued included the ability to be flexible yet maintain firm boundaries, being open to collaboration with the client, and allowing co-creation rather than being categorized and treated with pre-existing formulas. Some participants emphasized the therapist’s honesty, “I needed someone who could be



honest and straight and challenging”. Another aspect valued in a therapist was the ability to provide a safe space by remaining “very present”, “trusting the process” and “not rushing to fill the space ... and understanding that just that in itself can be a changing experience”. These findings on the qualities of the therapist are comparable with the findings from other studies (Higginson & Mansell, 2008; Perren et al., 2009; Rayner, Price, Hotopf, & Higginson, 2011).

Participants expressed preferences for therapists who either shared the same world view or were willing to explore and subsequently incorporate the client’s perspective into the treatment: “using my world view and my values, for example, spirituality, and putting that into the mix to help in the issue, is very, very important”. Additional facets included the therapist’s ability to “relate to my world view and have experienced it, but perhaps not necessarily be a step beyond it, but see beyond it”, and have a “sense of empathy” for the ways in which the client thought about the world. Participants also stressed the significance of knowing that “they are [therapists] not perfect, I am not perfect and that we are both learning together”. Furthermore, valuing the therapist’s theoretical and practical expertise was of significance, “for me it needed to be respect for both her theoretical understanding of the issues and her therapeutic skills”.

For some participants, therapists’ ethnicity, religion, and philosophical orientation were of relevance. Compatibility on this level often facilitated smooth development of the therapeutic alliance as it ‘implied’ to some clients deeper understanding derived from a similar background and/or experiences. It had an effect of very quickly creating a sense of familiarity, safety and trust. It also alleviated potential for misunderstandings and often enabled participants to have more open discussions about their own background and beliefs:

With a European person you feel warmth and a connection, but this lady was very Australian. She lived on a farm, I think, and came from a country town, and I just didn’t feel she had the experience or the depth of feeling. Whereas from this [other] therapist I could feel empathy and sympathy, you know. I felt like her and I were kind of on the same level, same cultural - - ... culture and tradition are very important to me .... But this other woman I just couldn’t attach myself to her.

Amongst dimensions on which clients and treatments have been matched, similarity of racial and ethnic identity has received considerable attention of the researchers (Cabral & Smith, 2011; Erdur, Rude, & Baron, 2003; Mollersen, Sexton, & Holte, 2009). Studies on racial/ethnic matching however have not produced conclusive

results. For example, a meta-analysis conducted by Coleman, Wampold, and Casali (1995) reported that ethnic minority clients, especially those with strong cultural affiliations, prefer ethnically similar therapists. However, they also noted that clients generally attribute less importance to the ethnic similarity than to characteristics such as attitudes, educational level, personality, and maturity.

The therapists' age was recognized by some participants as important, in that being in the same age group represented an assumed maturity and knowledge that would be of greater assistance to the person in treatment. These similarities offered the promise of being understood and also promoted a feeling of belonging. Analogous to this research some studies indicate that clients often equate similarity with credibility (Ames, 2004). Studies, however, also point out the fact that perceived similarity with others, whilst reducing stereotyping, also increases the likelihood of projecting one's own traits onto others (Critcher & Dunning, 2009).

Past experiences also allowed participants to develop a sense of what 'type of therapist' they would feel comfortable with and able to establish rapport. However, participants often struggled to provide a specific description of the therapist's characteristics necessary for the rapport to develop: "Although I had been to a therapist previously I had been to a couple that didn't suit me, so I knew the difference"; and "It is a feeling, I intuitively knew she was the one". This might speak to the difficulties of defining the complex and often elusive nature of intrapersonal and interpersonal factors. Further to this, participants did not want to be seen through the lens of theory. Such an approach was often experienced as depersonalizing and in many instances precluded development of therapeutic alliance. One participant described his reaction to this in the following words: "I just didn't connect with them. I couldn't be myself. It was almost like talking to them and saying, 'Well, this is what you want to hear'".

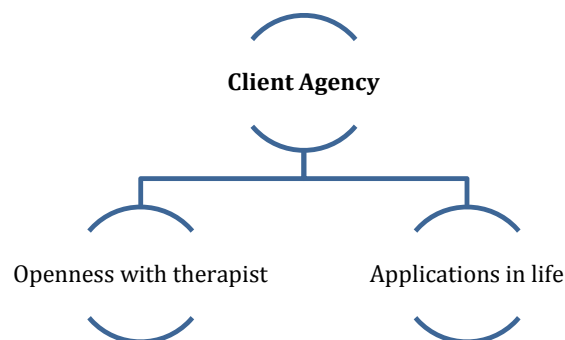
There were two main pathways to finding a therapist. Typically, participants relied on some form of recommendation in making their choices. The most common one was the recommendation made by a trusted friend or another professional, and the second one was the recommendation made by a general practitioner. Although it was not a rule, therapist-participants were often more specific as to the preferred personal characteristics and theoretical orientation of the therapist. It seems that having knowledge in this domain they were better able to articulate their choices.

However, there were also instances where therapist–participants did not know what specifically they were looking for in a therapist:

It is interesting because when I chose this particular therapist, like I said, just a couple of months before I went, I went to a therapist that I think it felt like it was sort of increasing my distress, but I heard a friend ask one of the lecturers at uni about who they would recommend and heard this name come up and then the name must have just stuck in my mind as someone who was good. So that's why I chose her. I never asked her how she worked because I wanted to really just be a client. I didn't want to go there as an academic exercise. So I wouldn't have really, and it crossed my mind a few times to ask her how she works, but it did feel important to just be a client and not sort of be academic about it. So it was really just that I had heard that she was good. I didn't really have a sense of what was going to be helpful or why. But that is probably why I engaged with her because her style must have suited and met my needs quite well compared to the guy that I had seen previously. That obviously didn't feel like it was the right fit for me.

### **Client Agency**

Over the past few years the concept of client agency has received some attention from psychotherapy researchers (e.g., Bohart, 2000; Bohart & Tallman, 1999; Dreier, 2007, 2008; Duncan et al., 2010; Rennie, 1990, 2001). Such research has focused on how clients use psychotherapy to change, how they communicate disagreements and disappointments experienced in therapy, and the level, nature, and reasons for concealment from their therapists. The current study explored ways in which clients express agency within therapy sessions and externally. Study data revealed that clients engage in both creating aspects of therapy as well as receiving them. They did this in a number of ways, including active evaluation of a therapist's skills and attitudes in determining when, what, and how much to disclose. They also provided multiple examples of their use of insights generated within therapy in improving both their personal and professional life.



*Figure 12.* Client Agency.

**Openness with therapist.** This section focuses on the phenomenology of participants' self-disclosures at different stages of treatment, including their perceptions of their own and the therapist's thoughts, feelings, and behaviours that influenced that process. The two interconnected facets of the process included the tendency to initially withhold and censor thoughts and reactions, which over time developed into more open and honest communication. Generally, the initial stages of therapy were characterized by a reluctance to share deeply shameful and unacceptable aspects of the self. In order to overcome fear of judgment and rejection, participants needed to first establish a very trustworthy relationship with the therapist. Only in later stages were they able to offer more open and honest expressions of themselves, but also of their reactions towards the therapists.

With few exceptions, the process of censoring and withholding sensitive and shameful material occurred during early stages of treatment: "I put the brakes on and censored myself a little bit initially". In the later stages of treatment, when trust was solidified, participants were less inclined to conceal information. They were adamant that the therapeutic relationship needed to pass the test of trust and understanding for personal control to be relinquished, and for sensitive and valuable information to be shared: "In the beginning ... that was just a lack of trust on my part. It took about a year before I would totally trust". Another participant who had completed a seven-year-long therapy indicated that concealments took place "all the time", but tended to decrease over time. She elaborated on her experience in the following way:

There were things that I sort of withheld, but by the end of seven years, there wasn't that much .... there were things that I withheld for a time but then they came out at some point .... I seem to have quite a strong internal censor. I'm not one of these people that trips themselves up often and just blurts things out. I have got a real strong connection between my mind and my mouth, and I would often censor, 'If I say this, she is going to think that and then she is going to ask me about this, so I'm just not going to bother.

This segment highlights the critical importance of time for mitigating fear of judgment and promoting open disclosure, and is in line with Kelly's (2000) contention that clients' concealments are a means of preserving self-image. He postulated that non-disclosure serves to protect a positive self-image and that these concealments had no negative effect on the therapy process and outcome. Hill, Gelso, and Mohr (2000) have argued otherwise, indicating that concealments are relatively rare, but that they have a negative impact on the therapy process and

outcome. For example, one study showed that clients concealed only fourteen per cent of their reactions out of which only six per cent were coded as negative (Hill, Thomson, & Corbett, 1992); similar findings were reported by Hill, Thompson, Corbett, and Denman (1993), where 54 per cent of clients reported no concealments, and 34 per cent disclosed to their therapists all of their in-session thoughts and reactions. They further found that clients withheld, on average, one thing per session. In terms of the relationship between client concealment and therapy outcome, findings were inconclusive; there was no correlation between level of concealment, symptomatology, and overall therapeutic change. However, despite the lack of data clearly indicating a connection between self-disclosure and positive therapy outcome, there is a strong consensus amongst therapists, irrespective of their therapeutic orientation, that client self-disclosure is fundamental to the process of psychotherapy (Farber, 2003; Goldfried & Davila, 2005).

This study indicates that the most commonly stated reasons for withholding were embarrassment, shame, and fear of judgment: “I was afraid to look silly, look not professional because we were in the same profession”; and “when I am ashamed of it I would be concerned about my therapist’s response”. One participant expressed this in the following way:

Of course ... there are things that you are ashamed of. There are secrets in your life that you think, ‘Oh no, I’m not going to tell him that. They are just too bad’ you know, because the therapist, they are important figures in your life. It is like telling your dad that you are an absolute shit or something. So I think that is probably being ashamed is one of the most important things that you don’t say to your therapist what is happening .... It depends. If you fall in love with your therapist obviously you probably don’t want to say much.

In light of these insights, it is not surprising that sharing sensitive material occurred in the later stages of therapy that typically were characterized by sufficient levels of trust.

In the early stages there were particular things that I held onto, but maybe it was more being less inclined to go as deeply with things or go into particular topics.... that was about building up trust and learning that the relationship was trustworthy and unconditional, which I guess was what was healing ... one of those factors that were healing in themselves.

These statements are resonant with the study conducted by Farber, Berano, and Capobianco (2004), indicating disclosure to be shame and anxiety generating, particularly in the initial stages of treatment. They concluded that withholding and keeping secrets had an inhibiting effect on therapeutic work, whereas disclosing

generated a sense of relief from both physical and emotional tension; it also produced a sense of pride, safety, and authenticity, subsequently increasing future disclosures. Psychotherapy theory and research have long advocated openness, honesty, and self-disclosure as having therapeutic value in symptom reduction and healing. This view of open disclosure of hidden thoughts, feelings, and experiences as central to the process of psychological change is particularly dominant in analytic, psychodynamic and process-experiential therapies. For instance, Jourard (1971), in his pioneering self-disclosure research argued that treatment outcome largely rests on the client's ability and willingness for honest self-disclosure. Similarly, Pannebaker and Francis's (1996) study linked written self-disclosure with symptom reduction. Data from the current study points to the conclusion that it is of utmost importance for therapists to actively pursue and assist the clients in accessing material difficult to disclose.

Apart from having to develop trusted relationship participants reported the need for a psychological readiness for disclosures. This often required addressing more immediate or surface-level issues: "It was done and dusted, but we had got rid of all the other stuff that I thought were all my major problems and eventually we could go back". One participant provided the following description:

It took me a long time to get to both of them [issues], particularly the last one because I hadn't even told her. I had probably been going for four-odd years and I hadn't even mentioned the car accident, and it just happened. We were going through a whole lot of other stuff that she was asking about and I was giving a chronological of some things that had happened and she said, 'What car accident? You haven't told me.' 'No, I didn't think it was important.' I just thought there was so much other stuff and I thought, 'I have put that away and I have dealt with it.' I obviously wasn't ready to get that out and look at it.

This is significant data pertaining to clients' emphasis on their psychological readiness for disclosure, which often needed to be built over time. Perhaps one of the reasons was that some material of greater significance could not be spoken about until there was a capacity to experience its affective components. In other words, the client's readiness to feel took a very long time to develop; once this stage was achieved feelings could be brought into words and produce desirable therapeutic effects. I would argue, therefore, that premature disclosures do not generate lasting change as they rely on words to generate feelings and not the other way around. This finding may explain why there is no correlation between level of concealment and symptomatology and overall therapeutic change (Hill, Thompson, & Corbett, 1992;

Kelly, 2000). If it is the readiness that determines how therapeutically beneficial the disclosure is for the client, then premature disclosure may not lead to significant positive change, hence remaining insignificant or even detrimental to the outcome.

Findings from this study also showed that the client's readiness to disclose is interlinked with the therapist's readiness to become a recipient of disclosure:

Also a sense of wanting to have things to myself ... a feeling of wanting them to earn or me wanting to kind of trust them more before I told them that stuff, getting a sense of wanting to understand who they were as people before ... and whether they would even get some of that stuff.

In this case, client did not simply volunteer information, but instead actively tested therapeutic situations for signs conducive to self-disclosure. This process of self-revealing rested on the client's conscious and very active ongoing evaluation of the therapist's attitudes and abilities, as well as their capacity for grasping the complexity of the client's presentation. This went beyond just needing to feel safe with the therapist; the ability and willingness to receive sensitive information, to tolerate, to understand, and to be with the client were tested. It appears that participant mutuality, that is, shared trust, was determined by the degree to which these qualities were present. Bollas (1987) describes this as an interactive context in which connections between the therapist and the client are made. He argues that a therapist has to prove that he or she is able to live within the environment created by the client who "suggests an environment within which both are meant to live a psychoanalytic lifetime together, and the analyst must suffer the illness of such place" (Bollas, 1987, p. 142). This indicates that it is the therapist who needs to undergo a psychic change in the initial stages, and this may be what "earns [him or her] the right to know".

Participants who took a very long time to disclose significant events often said that it was not a conscious or deliberate withholding: "I didn't consciously think, 'I am not going to tell her that' .... it just never came out, and when it did come out I was quite happy to talk about it. I guess it was all about timing". Under some circumstances, participants chose to lie to their therapists. One of the common reasons was protection of the relationship and preservation of the good image of the client and the therapist: "I didn't want to let him down"; and "I felt bad about myself when I lied to my therapist and I felt better when I then corrected myself a couple of weeks later". This participant further explained that: "even though I didn't particularly want to, I had to talk about it otherwise it couldn't be worked out". The

more conscious withholding was at times related to in-session time constraints, that is, some participants identified the need to be selective in their disclosures and focus mainly on the relevant issues due to the insufficient time for various things to be processed: “No, I actually don’t want to talk about that at the moment and I don’t want the focus taken from where I am at the moment”. It is very important for therapists to know that clients prioritize their disclosures, based on a complex assessment of time availability, therapists’ capacity for an accurate comprehension of disclosed material, and ability for succinct communication of its understanding. The study material indicates a general tendency for the concealments to decrease over time. It also indicates that the reasons for withholding and censoring are different at different times in treatment.

Far less commonly, participants expressed the view that certain issues should remain private due to their sensitive and highly personal nature. For example, one participant reported that she was unwilling to speak about certain issues, regardless of the potential benefits of self-disclosure: “some things I think are private, so I don’t discuss them with anybody”. Amongst reasons for non-disclosure was a belief that certain omissions were irrelevant to the process of therapy, that they could serve as distractions and derail therapeutic work: “I felt that they would get in the way, they would throw the therapist off track, the therapist would make too big an issue out of something that I had no issue with, kind of a red herring”. Another participant explained his reasons for withholding and censoring personal material in the following way:

They had to have occurred a long time ago—no, that is inaccurate—I had to believe they weren’t having a significant effect on my current life. Whether it was accurate or not, that is a different question, but I had to believe that. And I had to be deeply ashamed of whatever it was; so, if it fulfilled those two, I didn’t feel like it was having much of an impact now, and I was deeply ashamed of it, I would omit it from therapy.

He continued on explaining:

Even though it was a ... long-term therapy, at the time at least, and I would still make an argument for this, I felt like it was simultaneously something I was ashamed of and something that wasn’t important .... So I shaped it in some ways out of some sort of idea of efficiency possibly, like, ‘I don’t think this is important.

This excerpt illustrated the rationalizing employed in maintaining silence on significant issues. On one level, this participant made himself believe that the material not spoken about was not relevant. However, on the other hand, he had



awareness that unspoken issues were deeply shameful and could not be easily relinquished into the relationship. The complexity of the process described by this participant can be, to some extent, understood within the context of defence mechanisms. McWilliams (2011), in her discussion on secondary defensive processes, explores the function of the intellectual defence of compartmentalization that occurs when discrepant activities are accessible to consciousness. The behaviour described here is reminiscent of compartmentalization. In order to avoid shame, guilt, or anxiety this participant maintained conflicting attitudes of openness as therapeutic, yet withheld shameful information from the therapist. It is important for the therapists to be cognizant that such defensive manoeuvres may occur in the therapeutic process and their maintenance may be important to the client's sense of safety: "I was able to have that sort of control where I didn't feel like I was pressured into going into something I didn't want to go into. That is really important". Presence of this defence mechanism demands from the therapist skill in providing two distinct types of functions. One lies in interpreting and challenging defences, which helps the client to gain insight into his predicament and thus resolve it. The other function, which is not only harder to define but also harder to implement, is more in the nature of providing coverage for the client's defences until they are ready to be relinquished. Based on the current findings it seems, however, that the main difficulty lies in striking the right balance within these two types of functions in the therapist.

The two factors that emerged most strongly from the data analysis were the readiness for disclosure and the strength and safety of the therapeutic relationship. These findings clearly showed that time was required for the clients, not only to access these intransigent issues, but also to consciously experience deep-seated concerns and fears. Hall and Farber (2001), in their study of 147 therapy clients also reached the conclusion that time and the therapeutic alliance were the strongest predictors of overall disclosure. Research findings are inconclusive, in that some studies show self-disclosure as contributing to healing (e.g., Hill & Corbett, 1993), whereas others indicate a lack of positive correlation between client disclosure and outcome (e.g., Kelly, 2000). The findings from the present study suggest that these two opposing views are, in fact, not mutually exclusive and might be both accurate. It is the process of self-disclosure, not a disclosure per se, that leads to healing. That is, if the client is not psychologically ready to disclose and the therapeutic alliance is

not strong, then perhaps such disclosures will not lead to positive changes. If, however, the client is allowed time which is met with deep understanding from the therapist it would most likely account for a positive change.

**Applications in life.** Generally, participants experienced a sense of agency, as a result of application of learnings from therapy into their life. This manifested itself through making connections between experiences in various contexts, of which therapy was only one, and utilizing these experiences in implementing changes. Whilst all participants acknowledged improvements within the interpersonal and intrapersonal dimensions, therapist-participants reported multiple additional benefits relevant to their professional life.

Some of the commonly reported learnings, which were frequently utilized outside of therapy, pertain to emotional facets. The participants recognized that feelings experienced in the session were something that they were able to take with them; they were still alive after therapy: “I would take away the feelings”. Here, agency manifested itself through an active learning: “It is the experiencing ... you are living it, going through it”; and:

it gets provoked in that experiential way and you have to save it, you have to process that, and yet new meaning forms out from that. I don't know how, but somehow if you go through it and you stay with it, new meaning comes out from there.

This agential learning was distinguished from being taught specific skills; it was more about discovering it experientially, “discovering it for oneself”. That sense of being able to learn, to discover, as opposed to being told, played a crucial role in the subsequent ability to apply these learnings into life outside the therapy. These kinds of learning originated in bringing into the session life experiences, examining them, and then taking them from the therapy room into the outside world:

I was bringing life experiences into the session, examining them like in a little microcosmic world with the therapist and finding the symbolism in those moments, for how I saw the world and saw myself. And then, ongoing back out of the counselling room into the world, I guess applying those little mini-lessons and sort of spreading them out and kind of finding more moments that I could find more symbolism with.

Participants also talked about learning about self in the world by examining self in the therapeutic relationship. This type of agency had an effect on the whole person of the participant, on both interpersonal and intrapersonal and professional levels:

I was using it to be a better human being .... I was using it as a creative platform to create and generate something with another human being in a relational context, but also in that moment to dive deep, to go in at an emotional level a lot more and using

that to be a better human outside, to be a better husband, to be a better therapist even, to be a better family member or friend.

Personal therapy was seen as a *sine qua non* of psychoanalysis (Wiseman & Shefler, 2001), but over the years has received increasingly more interest from other schools of therapy. Professional training organizations view personal therapy as a valuable adjunct to professional development; they do not, however, deem it necessary. In America and the UK approximately three-quarters of mental health professionals have engaged in personal therapy, with the highest frequency amongst psychoanalysts and the lowest amongst behaviourists (Macran, Stiles, & Smith, 1999; Norcross, 2005). Some studies indicate a positive relationship between a therapist's own therapy and treatment outcomes (e.g., Norcross, Strausser-Kirtland, & Missar, 1988), whereas others did not find this relationship to be significant (e.g., Macran & Shapiro, 1998). In their recent review of literature, Orlinsky, Norcross, Ronnestad, and Wiseman (2005) also reported the lack of consistent evidence in support of personal therapy as a factor linked to the improving of treatment outcome. This, they argued, was largely connected to the poor quality of those studies. Some researchers (e.g., Beutler, Machado, & Neufeldt, 1994; Norcross, 2005) emphasize that treatment outcome is only one of many ways of assessing the benefits of personal therapy. Norcross, for example, identified six ways in which personal therapy can contribute to clinical practice, namely: greater understanding of one's own personality and its dynamics; improvement of one's own mental health; greater empathy for the client role and experience; socialization as a therapist; being provided with learning opportunities; and work-related support. Similarly, study participants indicated that personal therapy was highly significant to professional practice.

In the current study all participants recognized the personal benefits of psychotherapy; however, therapist-participants also spoke about the direct applicability of their insights to their professional practice. One of the common expressions of personal development was a newly acquired ability to reflect on one's own emotional reactions, which led to better emotional management. Participants recognized greater self-awareness, lower emotional reactivity, an increase in relational capacities, and overall personal growth. The mechanism of this process, in a more general sense, was described as 'modelling' or 'vicarious learning'. Often the interaction with an admired therapist subtly began to shape a participant's personal

and professional self: “a lot of vicarious learning going on. I think both as a professional and as an individual, I started to have a very strong sense of the subconscious level of modelling of her”.

The benefits of being in therapy were described in the following ways:

It has given me a renewed passion for psychology .... for me it was such a profound experience, that I do still find hard to put into words and really if I could just be with someone and give them just a fraction of that, I would feel like I had done a really good job.

One participant utilized therapy as an exploration tool: “some part of me used the therapy to develop myself, to challenge myself ... to push myself into zones that were uncomfortable and see what they were about and see how they feel and see what they mean to me”. For others, professional development was the initial reason for entering therapy, which over time became personal development:

I initially went because I was studying to be a psychologist and I knew it was a good thing to do, but I had this ball of pain and I thought if I’m so unfinished, who do I think I am to be attempting to this work? It was difficult to admit that I didn’t ... feel adequate, or people could see I’m me, that I was ... unformed or flawed .... And yet I couldn’t even identify many concrete things that I learned, so it was more the acceptance and the talking it through with her.

Having the experience of personal therapy was strongly advocated by some participants, as a precondition to deep and emphatic understanding of the process clients will experience whilst in therapy: “for me it was about practicing what you preach as well. I personally believe that it is important that if you have to work with people you should continue to work on yourself”. This concept was further developed by another participant: “you need to have this experience to be able to explore the depth of human relationship .... this is a deep relationship which is not necessarily the relationship with your family or friends, and that is a bit of what you want to have with any of your patients”. This participant, through the experience of personal therapy, recognized the uniqueness and deeper purpose of the therapeutic relationship; that is, she perceived the therapeutic relationship as an exchange between two individuals in finding answers to deep human questions. Similarly, Klauber (1981) understood the uniqueness of the therapeutic relationship and its implications for both participants:

Patient and analyst need one another. The patient comes to the analyst because of internal conflicts that prevent him from enjoying life, and he begins to use the analyst not only to resolve them, but increasingly as a receptacle for his pent-up feelings. But the analyst also needs the patient in order to crystallize and communicate his own thoughts, including some of his inmost thoughts on intimate

human problems which can only grow organically in the context of this relationship. They cannot be shared and experienced in the same immediate way with a colleague, or even with a husband or wife. It is also in his relationship with his patients that the analyst refreshes his own analysis. It is from this mutual participation in analytic understanding that the patient derives the substantial part of his cure and the analyst his deepest confidence and satisfaction (p. 46).

The emphasis placed on the availability of the therapist's own deep understanding that comes from experience was seen as indispensable for a productive and meaningful therapeutic experience:

It is good to think about what it is like for my clients at the moment, because sometimes I will say something and I will know that that came directly from my own experiences and .... I do believe really strongly that we should all do long-term therapy. And I say that when I am supervising people, because I think you need to know what it is like to be a client, even something as simple as getting to that point where you need to do something and what that feels like and what it feels like to ring someone and how you go about choosing them and what it is like throughout the whole process.

The complex nature of empathy, which deriving from similarity of experience, was expanded by another participant: "I'm not sure whether at those times my response is almost like in sympathy, where I understand what they are going through because it reminds me of my own insight, but I certainly wouldn't have learnt that without going through therapy myself". Others also appeared to see indispensable value in the resonant nature of experience:

While I might have somebody as a client who feels something, it won't be exactly the same, but I can still understand from a different level, and I feel that it enabled me to sit with certain feelings and be able to talk about certain things without being overwhelmed. I suppose it has expanded that ability to sit with different emotions and accept different emotions on a physical level rather than just on a head level, 'Oh yes, it is okay that everybody feels that' but to actually be okay with feeling that myself. So I feel that that is probably one of the most powerful things I have sort of learned.

She also stressed the value of the realm of felt-experience and being able to respond to the client from that space instead of having to intellectualize it. Similarly, others spoke about this aspect of development: "I think it is really important to be able to expand the amount of emotion you can sit with and the intensity you can sit with and to really understand yourself to help you understand somebody else". This was further explained in terms of the process of assimilating personal learning into professional practice: "it is quite interesting how much I learnt to assimilate into my practice of things that worked for me". This process of learning was also referred as balancing of "science and the heart" and was experienced as an intertwining:

I see it as a rope that a storm has twisted, and it is two pieces twisted and I feel like it is intertwining in that it is a balance, but it is a strength and because of that you can't tease them out. You can tease them a little bit here and a little bit there, but it is really important that it remains solid.

The learning here was an understanding that in life and in professional work, attending to cognitive, emotional, and body level functioning and striving for its balance is pivotal.

Another learning developed from personal experience was to prioritize the client's own experience of the therapy process:

Teaching people to trust their experience, because so often people don't ... they put that aside and have other explanations.... and to get people to let the story go and actually go inside and feel their own experience to say, 'What is happening to me right now?'

This is an example of an application of learning that resulted from understanding reached through one's own experience. This was not simply something one thought to implement in one's work with clients, but instead it was a product and an insight derived from one's own process of change. This participant talks about making an effort in his professional practice to generate an environment conducive to his clients having moments of insight. More participants recounted similar types of experiential learnings integrated to their own practice; for example, "she introduced me to the quotation, 'Don't just do something, sit there!' And it is an idea that I use a lot in my own therapy, sometimes indirectly, sometimes more directly .... It is not what you do, but it is what you don't do that is so valuable". Such learnings were often a combination of intellectual and experiential components and led to expansion of the scope of interventions and greater sensitivity to the client's needs:

My perception of what I was taught was to be much less directive, and I am much more directive in the way I do therapy now, not with everybody, but there are times when I will suggest things to people or I will give them more psychoeducation than perhaps I would have initially, because there is a part of me that doesn't want people to wait 15 years to work it out .... I developed a strategy to help me manage things that made me feel overwhelmed or destabilized or crazy...which I still use now, and I use in therapy with clients now. So it was really strong learning, and it is not that she said that to me. That was a strategy that I developed as a result of what happened in therapy, which seemed to work. I don't think you can learn this. I think it is something that happens with experience .... like my own experience of doing therapy, because I think it has changed a lot from my experiences of having being through this therapy, through this process. I think it is quite different. I am much more assertive in the therapy perhaps, and I just understand it all better.

Here, an emphasis is placed on arriving at clinical wisdom through personal experience and subsequent reflection on it. This participant stressed what others alluded to, in saying that the strength of her learning did not come from directive

teaching, but from the capacity to think and feel which developed through her own therapy. This is what, most likely, allowed her greater flexibility and freedom in choosing the most appropriate approach for clients at any given time. Strengthening the ability for self-reflection also resulted in a wider scope of emotions available for working with clients:

I developed a higher rate and a better quality of self-reflection and that ... allowed me to choose different ways of responding and behaving in therapy with others. By developing a greater level of empathy with the clients I am working with, because I now understand what is like for them to be sitting on the other chair - that has helped with establishing rapport and also maintaining the therapeutic relationship. So, I have actually been able to challenge assertively clients in session and have more faith in the strength of the therapeutic relationship that I have created with them .... It has given me a context to understand my own responses and reactions ... so that has allowed me to actually be less biased in my responses and have more flexibility in the way I respond to clients in session.

And she subsequently added:

Oh, and that is another thing that I have learnt, which is not being driven to try and force clients to have those moments of clarity and insight and understanding and self-reflection - allowing them to do that on their own but to be there with them, as opposed to trying to force them to have those moments, which is what I use to do before I started therapy, as a therapist .... I have gone through therapy myself, and I now understand that that process needs to be driven from within and it doesn't feel helpful when someone is trying to do that for you, an external person.

This account sheds light on the process of developing an understanding of conditions necessary for an insight to be generated. Ultimately, it was a personal experience that crystalized into a profound awareness of the dynamics necessary to produce insight. Awareness of the existence of an unconscious realm within the therapeutic work was particularly enriching for another participant:

For me there is more of a sense, at least around when I'm doing stuff that is unconscious ... sometimes it is just a sense of 'something is happening here and I'm not sure .... is that me or is that them?' But at least there is a sense of, 'Ooh, that feels, I'm not sure what is happening.' And, of course, it is invaluable when you are working with clients as well.

Data analysis in this study echoes previous studies and substantiates the value of a therapist's engagement in personal therapy. Previous studies (Macran et al., 1999; Norcross, 2005; Orlinsky, Rønnestad, & Ambühl, 2005; Wiseman & Shefler, 2001), identified improvements in respect to the therapists' own self-esteem, emotional expression, social life, and symptomatology. Therapists also found personal therapy to facilitated greater insight into interpersonal dynamics of transference-countertransference. More recently, Daw and Joseph (2010) explored

the experience of personal therapy amongst 48 qualified therapists. Participants in their study identified five reasons for engaging in personal therapy, namely personal growth, addressing personal distress, to prevent burn-out, to enhance self-reflection, and to fulfil training requirements. They recognized the value of personal therapy in facilitating personal growth and serving as a form of self-care. In terms of its value to the professional practice, experiential learning and gaining client perspective were reported as main gains. These results were replicated by the current research.

In summary, exploration of the participants' understanding into their problem formation and resolution yield some important insights into the process of change and the role allegiance, expectancy, and client agency play in it. While participants often had some approximate or more general understanding of the aetiology of their difficulties and possible ways of addressing them, they also recognized its insufficiency and the need for more in-depth understanding for change to be instigated. Associated with this, was a commonly articulated preference for the type of therapy, as well as therapist and therapeutic environment. In order to achieve optimal treatment outcomes, these three factors needed to be present to a satisfying degree. Another important finding in this domain were the ways in which clients express agency within therapy sessions and externally. Firstly, these included active evaluation of a therapist's skills and attitudes in determining when, what, and how much to disclose. The early stages of therapy were characterized by a reluctance to share deeply shameful and unacceptable aspects of oneself. The censoring and withholding were mitigated by the ability to overcome fear of judgment and rejection, which occurred in the later stages of treatment, when a trustworthy relationship with the therapists was well established. Secondly, participants experienced a sense of agency resulting from applying learning from therapy into their life. By and large, these understandings occurred within the emotional dimension and manifested themselves through improvements within interpersonal relationships. Therapist-participants also placed emphasis on arriving at clinical wisdom through personal experience. The next chapter provides more detailed insight into the clients' experience of the factors that were helpful and hindering to the process of achieving psychological growth.



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## CHAPTER Six

### Helpful and Hindering Factors

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The research literature established strong evidence that the client perceptions of therapy are more accurate predictors of outcome than those of the therapist. Therefore, these client experiences are of paramount importance in furthering our understanding of the processes that generate and obstruct treatment. Participants provided ample amount of data on what facilitated the process of therapy and enabled them to achieve positive changes. At the same time they were less forthcoming in identifying aspects that were hindering to the process of therapy and preventing them from achieving positive therapeutic change. This chapter provides analysis of factors that are responsible for facilitating as well as hindering psychological change.

#### **Helpful Factors**

The current study identified helpful aspects of therapy as being predominantly centered on the qualities of the person of the therapist and the therapeutic relationship. Participants emphasized the importance of a secure and containing therapeutic space, a real and deep relationship, a solid therapeutic alliance, and the therapists' warmth and realness. While the most important change facilitating aspects were related to the person of the therapist and relational milieu, specific therapeutic interventions received secondary acknowledgement. The analysis further showed that change facilitating strategies and interventions only become significant when infused with understanding that developed in the context of a meaningful therapeutic relationship. It is a well-researched finding that the alliance is one of the central components of successful therapy; however, what has not been so clear is just how significant it is from the client's perspective. This study differs from previous research, in that, the centrality of relational factors emerged from participants' spontaneous recall on helpful aspects of therapy. Table 10 provides a summary of key themes on helpful aspects of therapy.

Table 11. *Helpful Factors: Frequency of Occurrence of the Theme*

<b>Strong therapeutic frame</b>	<b><i>General</i></b>
Secure therapeutic space	<i>General</i>
Good boundaries	<i>Variant</i>
Predictability and availability	<i>Variant</i>
<b>Therapist as developmental object</b>	<b><i>General</i></b>
Containment	<i>Typical</i>
Secure attachment and attunement	<i>Variant</i>
Experience of re-parenting	<i>Variant</i>
Internalization of therapist	<i>Typical</i>
<b>Very solid alliance</b>	<b><i>General</i></b>
Acceptance, support, and non-judgmentalness	<i>General</i>
Real and deep relationship	<i>Typical</i>
Therapist's qualities	<i>Typical</i>
Rupture reparation	<i>Variant</i>
<b>Change facilitating strategies</b>	<b><i>Typical</i></b>
General therapeutic interventions	<i>General</i>
Model specific interventions	<i>Typical</i>

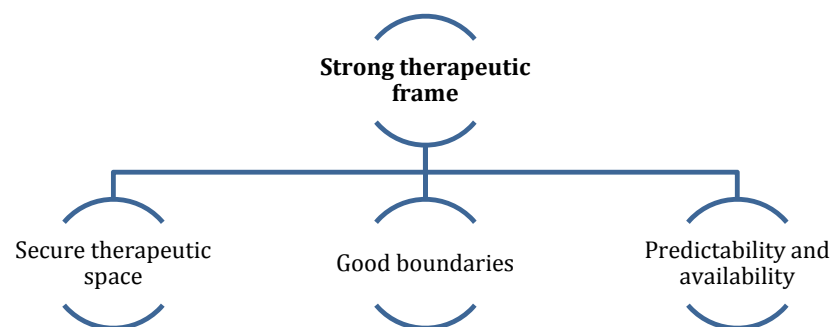
General: all cases or all but 1; Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

### **Strong Therapeutic Frame**

While there is some documented enquiry into the role of the therapeutic frame as seen by the therapist (Dryden, 1985; Wosket, 1999), no research from the client perspective has directly explored this aspect of therapy. However, the importance of the therapeutic frame was confirmed in descriptions provided by participants. Its value and qualities were typically reflected in the experience of having a predictable and reliable therapeutic frame, with felt security and safety provided by the therapist. It is significant that, in the current study, participants were not asked directly about the therapeutic frame, yet all spontaneously mentioned its importance when discussing helpful aspects of therapy. It is also significant that, irrespective of treatment modality, participants ascribed equal importance to a secure therapeutic frame. Given that most therapeutic models prioritize theoretical

conceptualization of interventions over the frame in which they emerge, it was somewhat unexpected that participants assigned foundational value to the provision and maintenance of a secure therapeutic space.

The importance of a therapeutic frame has been explicitly theorized in psychoanalytic literature (Milner, 1987; Gabbard & Lester, 1995), and more implicitly in other theoretical schools (Symons & Wheeler, 2005). It began with Freud (1958), who defined the ‘ground rules’ for analysis, and later Milner (1987) articulated the concept of the ‘therapeutic frame’, also referred to as the ‘therapeutic setting or space’. Langs (1977) divided the therapeutic frame into two components. The first is the contractual understanding, which includes constant factors such as absence of physical contact, confidentiality, location of meetings, payment of set fees, and length and frequency of sessions. The second component refers to interpersonal elements defining interaction, including non-judgmental acceptance and the attempt to understand the meaning of communication and behaviour. More recently, Luca (2012) defined the therapeutic frame as a ‘structure with rules’ that differentiates between that which goes on inside the therapy room and that which is outside of it. Gabbard and Lester (1995), on the other hand, described the therapeutic frame as an “envelope within which the treatment itself takes place” (p. 38); they also acknowledged this to be a dynamic and flexible set of conditions that reflect the ongoing process of responding to the client in the most optimal and useful ways.



*Figure 13.* Strong Therapeutic Frame.

**Secure therapeutic space.** Generally, participants considered a safe therapeutic space to be a pre-requisite to therapeutic work. The role of a secure therapeutic space is emphasized in the following excerpt:

What else was helpful? ... in terms of the framework of therapy, my therapist, we got a set day and time that became my time and ... week in and week out that was when I had my therapy. And it was a set fee, a set negotiation around missed sessions, cancellations, so that was all useful, because I like to have all that.

Here emphasis is placed on the importance of a ‘setting’ which is static, constant, and solid. Even though not explicitly stated, the sense of safety that a predictable environment can offer emanates from this description. This frame introduces ‘me time’, that assigns importance to, and builds acknowledgement of, the psychic reality of the individual. Provision of such frame may foster the ability to position oneself within the space and began cognitively and emotionally to map it with one’s own psychological material. Another important issue, alluded to by this participant, is the agreed time and space frame that offers protection from the potential disruptions of the outside world. Likewise, much psychotherapy literature, emphasizes the importance of maintaining a consistent ‘setting’ that is free from external and internal intrusions, including the intrusions from the therapist (Birksted-Breen, 2010).

The establishment and maintenance of a therapeutic frame creates an atmosphere of safety in which the client can regress and work through powerful affects, without fear of impingement or judgment:

It was a very safe space where I could drop my guard completely and be very raw and very open and very childish or adultish, or whatever you wanted to be, I could be without judgment, not judgment but without prejudice is probably a better word. And with the safety - that whatever I said stayed there. So that was very good for me; that was very helpful for me.

This excerpt illuminates how clients are able to experience themselves in a new light, precisely because the rules differ significantly from other social interactions. This echoes Rouholamin (2007) who argued that the role of the frame is to provide a sufficiently secure space for the client to be safe enough to explore what is unsafe.

Participants described experiences that emphasized the containing and holding role of the ‘frame’: “he was very consistent”, “feeling that you are in a secure place”, “she was always punctual”, and “we would always start and finish on time and she was very gentle about that, but persistent, ...you felt really contained

and safe”. These descriptions strongly resonate with Gray’s (2000) emphasis on the importance of components such as continuity, consistency, security and safety; “these variables act in the service of a structured, safe environment that has the strength to hold and contain the emotionally turbulent processes of therapy” (p. 34). The significance of the consistency, and containment is well described in the following accounts:

I suppose that consistency that she brought to therapy was really helpful for me, particularly when emotionally things are quite erratic it is, I suppose, a bit like a stone in stormy waters. It is something to cling to. And, you know, ‘Okay, this person is going to be like this’ although you might not feel it when you go in, but in hindsight that consistency was really, really important.

Within therapy, being able to discuss situations in a safe contained area that, on one hand, moderated my level of emotional reactivity yet, on the other, gave me freedom to express my emotions in whatever the way I felt were beneficial to me and through that emotional freedom allowed greater personal insight and a greater understanding into interaction processes between me and others.

The importance of the therapist’s ability to provide a model of care that emphasizes continuity and consistency is stressed. Gray (2000) described this model of care using an analogy between the frame and a mother providing care for her child. Here, the consistency and continuity is like the feeding pattern which is gradually established and provides a regular period of time set-aside just for the client.

It seems that for some clients, the physical setting in itself becomes the object of deep attachment, especially for those whose early experiences did not offer a security that they could take for granted. One participant described having a strong reaction to the containing role of the therapeutic setting:

It could really isolate this stuff and keep it in this little room and not allow it anywhere else, which I think helped package all the emotions when I would leave the room. I would be able to leave them behind and come back to that when it was my time and my space to come back to that. I think that element of it really helped.

This excerpt illustrates how ‘the setting’ is more than a reference to the physical layout and the practical arrangements. The therapeutic setting is not commonly given a lot of attention within psychotherapy literature. However, within psychoanalytic literature ‘the setting’ is seen as a participant in the client-therapist interaction. For instance Birksted-Breen (2010) views ‘the setting’ as the guardian of the therapy, a silent participant. The quote above is an illustration of the significance of the therapeutic space. This participant sees the therapeutic environment as a distinct space and time that offered a safe space in which difficult material could be

processed and 'left there'. In psychoanalytic literature, the significance attributed to the setting is often understood as a "holding function", which is provided by both the therapist and the setting. As proposed by Winnicott (1986), the concept of holding implies a background object, which facilitates maturation, without being involved in a direct "I-Thou" interaction. According to Grotstein (2007), the "holding environment" offers more of a passive function in providing the client with a "background presence of primary identification".

Participants strongly indicated, that not only the therapist, but the room, the time, and any other aspect that contributes to the therapeutic space functions as a container. The client's emotional material can be securely stored within the setting and within the therapist. Having this designated time and space allows the client to 'safely deposit' and 'leave behind' disturbing material until the next session. It seems that the experience of consistent provision of a secure frame is more important than the verbal assurance of safety and containment.

Overall, participants described a secure therapeutic space as a protected private space in which inner thoughts and feelings could be looked at. The essential component was the frame of constancy and immutability that allowed delineation between the outside and the inside of the session. Safe emotional enactments were possible, partly because they were contained within 50 or 60-minute sessions with a predetermined beginning and an end; as one participant exclaimed: "wow! Someone is actually doing this for me.' One hour was so cool! So that was really important". The therapeutic space encompasses firmness, repetition, and constancy while at the same time allowing fluidity, unpredictability, and discontinuity, ultimately enabling the client to 'travel' to unknown and distant parts of the mind (Birksted-Breen, 2010).

**Good boundaries.** Participants provided numerous examples that indicated that the maintenance of boundaries was a necessary component of a strong therapeutic frame. The initial stages of establishing a secure therapeutic space involved various forms of boundary testing: "not that I was misbehaving, but emotionally all this stuff was coming out, push, push, push, 'Is this safe? Are those boundaries real?"; and "it was almost like pushing at all those boundaries to see if they were safe. And as they were, that was when perhaps we could move through some of the harder stuff. I didn't have an excuse to blame. Damn it!". Thus, clients could decide on the depth of psychological work based on the strength of the

therapeutic boundaries. The function of boundaries is to define the parameters of the therapeutic relationship, so both therapist and client can feel safe while also being spontaneous (Gabbard & Lester, 1995; Peebles, 2012).

Participants strongly affirmed the view that clear boundaries are necessary in order for client and therapist to be fully present and open without arbitrary barriers: “I had a lot of trust in her professional boundaries”; “I already know there are certain professional parameters and she was very steady with those, and I think that was really important”; and:

This woman was crystal clear. There is no blurring of anything. I talked to her about maybe doing some supervision with her and she said, ‘You need to wait six months because if we do supervision you can’t have therapy.’ She was really clear and I really needed that.

Another participant emphasized the importance of the ‘rules of therapy’:

She has got these boundaries. I know them. I know the rules in this room and the rules are good. I like the rules. The rules are in there like the road rules.’ So, I suppose, in that way it matched my expectations and allowed me to feel safe in there to allow me to go through this place that was just dark and scary, and not know what was happening and move through that internal chaos where it was just like having somebody who was doing what I expected or wanted .... there were these rules that she stuck to that gave me that real structure to feel safe within that and allowed me to move through that to come out at the end and to be able to reflect and go, ‘That was a good call. I’m glad I did that.’

Boundaries were also understood in terms of the interpersonal dimension of the setting:

She has never revealed a great deal of herself, but I think I’m okay about that. That was not necessary. She revealed things about her professional life and things like that, but, no, I started and finished a patient ... I needed to be a patient, and she said very clearly up-front that she thinks of her clients as patients and there wasn’t this sense of equality, which I could perfectly understand.

The following excerpt pertains to the role the boundaries play in creating an optimal therapeutic relationship, which in its essence is asymmetrical in that the space is given over to the client and for the client’s benefit:

I didn’t have to sit there and listen to his story as well. I don’t know much about him. It is not what he is there for, and I felt very comfortable in that relationship. I didn’t have to give him anything. I gave him money, but I didn’t have to give him time for him. It sounds terrible, but that is what I enjoyed about it, that there was no expectation for me to sit there and listen to his story.

**Predictability and availability.** Another component of a strong therapeutic frame relates to the experience of the therapist as being both predictable and available. Participants identified predictability, within the context of therapeutic interaction, as having a stabilizing effect: “there is nothing unexpected”, and

“nothing was really sprung on me”. Predictability also served as a factor minimizing ruptures within the therapeutic couple:

There was, I think, probably a maximum of twice maybe in the whole seven years where she might have called me on the morning that she was really sick and couldn't make it and could we reschedule to next week or something. And even that wasn't a rupture for me. It wasn't ... 'Oh, you don't like me. Why are you cancelling?' It was purely, 'yeah, of course', 'you sound really sick, and get well soon.'

For some participants a sense of security came from the therapist's willingness to be accessible outside of the session time: “She was always a phone call away. If things got too distressing, you could always make a call”.

Another important aspect of the secure therapeutic frame, deriving from its predictability and availability, was a sense of trust and faith. Some participants talked about having “trust” and “faith”, as these factors helped them get through the process. Bion (1962) makes an interesting comment on the nature of faith; he states that the ability to tolerate frustration requires the development of faith. This, however, fundamentally depends on the infant's experience of maternal absence becoming constantly conjoined with the mother's return. The same process can be observed within the secure therapeutic frame with the therapist, who, after predictable periods of absence, returns also in the predictable time-space frame. Therefore, the statement “I felt it was a process of faith to some extent” can be seen as indicative of faith being a developmental faculty which does not precede, but instead results from the security of therapeutic space:

I suppose the ability to be able to contact her if I needed to was important, but also her boundaries around that. If I really needed to then that was fine, but I'm not the type that would be ringing someone unless it was just too much. At one point I did call her .... So having that person to just go 'Roar!' when those emotions were really strong and just to be able to release them to somebody else was really important.

The above excerpt illustrates, however, that availability needed to be accompanied by a sense of predictability guarded by the clear boundaries. The need for clear boundaries was also reflected in participants' caution in utilizing such help. This was given expression in the following statement: “and even though she offered me those extra supports like her mobile phone number and things like that, I was always very respectful of that”. Therapists' availability was further equated with an ongoing presence: “she was accessible 24/7, just knowing that, even when I wasn't with her, I was able to call her and get advice over the phone and I just felt like I had someone

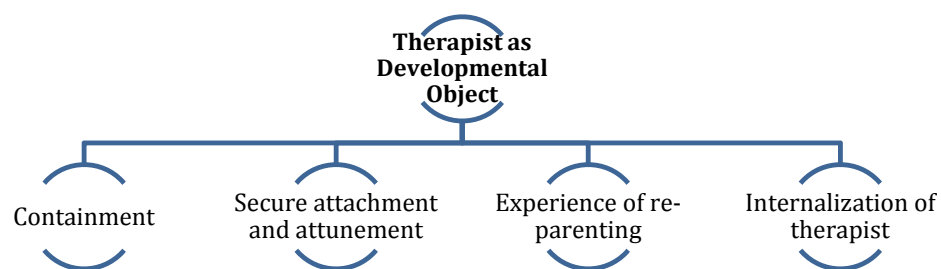


with me... so I felt very secure”. The significance of getting the balance right between keeping a firm and structured frame while demonstrating flexibility emerges from these descriptions.

These findings are unique in the sense that they emphasize the importance of the secure therapeutic frame, as perceived by the client. While therapists generally are aware of the role of a strong therapeutic frame, they may be surprised to see that clients place an enormous importance on a strong and secure frame. What clearly emerged from the current study are the client’s perception of both the overt and the symbolic significance of a secure therapeutic space, as one of the central pre-requisites to therapeutic work. These findings support the need for a more active discussion of the role and function of the therapeutic frame to the therapeutic process in all models of therapy.

### **Therapist as Developmental Object**

Participants’ experiences of their therapists were generally described in the context of developmental functions. These processes were classified under the following themes: ‘Secure attachment and attunement’, ‘Containment’, ‘Experience of re-parenting’, and ‘Internalization of therapist’. While all of these concepts have received a lot of attention on the theoretical and empirical level, there is again, a dearth of empirical data on how clients’ experience these processes and the meaning they ascribe to them (Arthern & Madill, 2002).



*Figure 14.* Therapist as Developmental Object.

**Containment.** Typically, descriptions provided by participants indicated that therapists functioned as a container for the unprocessed, not yet understood feelings

and thoughts, as well as chaotic thoughts and feelings that required transformation. The following excerpts provide vivid descriptions of various facets of the experience of being contained:

I knew she was there. I knew by the intensity of feeling in the room but I knew she wasn't being pulled under by me and that she was able to hold the fort for us both, and yet I never really saw her well up or anything like that. I believe she would, yeah, by the intense feeling in the room. Yes ... perhaps I knew it was genuine, because she would go in after it .... so because she was brave enough to go after this and allow it, maybe I accepted that she wasn't afraid of it and she was there. So I knew by her behaviour, her stillness, and I knew by her going after the tears, and I knew by her lack of alarm, lack of agitation, lack of movement, like, you know trying to rescue me by putting tissues at me. I knew by those things she was cool, she was comfortable, and I knew perhaps by the questions afterwards exploring that. No empty reassurances, no panic, no agitation in her. I think that is why I would experience it as very real, yeah, and that would be the way she could be real, because obviously it wasn't a place where she could express her emotions.

But it was about actually allowing those emotions up, sitting with them with somebody who could accept me with those emotions, and allow them to subside, come up, subside, allow that part of me to grow to start matching what I thought and not just thinking it and saying it and pushing those emotions down because they are not really matching. And even behaviourally, you know, I think I can do the right things. I can look after myself. I can do this and that, but that internal stuff just still, perhaps it was just underdeveloped. This shell that you built around yourself with all the theory and what you do and all the rest of it, that shell, and perhaps that's what it was. Maybe that's what it was at the end, just about filling me up and everything just felt full, matched, balanced, but it was contained.

These descriptions indicate that the therapist's ability to provide a containing function can have a healing effect; its growth stimulating function may lie in restoring emotional ties to experiences, resolving both internally and externally manifested conflicts, and offering new self-knowledge.

The material presented by the participants can be interpreted within Bion's concept of the 'container-contained' (1963). He theorizes that thinking requires a positive 'container-object' which develops in the following sequence: the infant projects his or her raw emotions (proto-emotions, 'Beta elements') into the maternal container, who is able to absorb, sort out, detoxify, and transform these elements from uncontainable to containable. In order to do this, she needs to be able to reflect upon these projected communications, allow them to incubate within her, while at the same time allowing them to resonate with her own emotions and memories. He further argued that this subsequently leads to the transformation of infants 'Beta elements' into 'Alfa elements' that are suitable for mentalization. If the 'container-object', in this case mother, is able to successfully perform this task, the infant will

be able to introject this experience and by doing so establish the origins of autonomous thinking. This means that the process of mentallization can be taken up by the infant for him or herself (Bion, 1963).

Bion (1962; 1963) stressed that the ‘container-contained’ concept applies not only to the mother-infant dyad, but is equally applicable to the therapist-client relationship. In this case, it is the therapist who provides a containing function in the same way as the mother. The therapist is able to bear and absorb the client’s emotional states, transform them, and interpret them back to the client. These stages are evident in participants’ descriptions of the therapeutic process: “expressing a lot of unhappiness and frustrations and having that contained was more helpful”; “[therapist] just allowing you to be where you are at”; “[therapist] noticing if things were all of a sudden becoming too much.... monitoring that as we went along and allowing me to think, ‘Well, no, I can go further’ or ‘No, I rather not get into that’”; the therapist’s ability to bear and work with the strong affects: “I didn’t have to protect him from it”, “I can’t tell you how much I cried very deeply...like howling crying, and she would be really, really still. I guess in that to me I believe was a genuine”; allowing internalization and re-introjection: “I think by her behaviour towards me I began to see myself as okay and then I began to, I suppose, internalize that. And she didn’t say very much at all, so that is interesting as well”. These quotes indicate just how important clients find the therapists’ function as a container, translator, and modifier of unprocessed and previously uncontained feelings into a more containable format. They indicate that the therapist’s function as a container is a complex one; it required the ability to receive and neutralize unprocessed material, in order for the client to re-introject it in the modified form. The experience of a ‘good-enough’ external container, in the therapeutic relationship, enables the client to develop a ‘good enough’ internal container, with which to regulate and mediate emotions and thoughts. Similarly, Green (2003) in her attachment theorizing state that “the psychic scaffolding offered by the therapeutic relationship can enable the patient’s intrapsychic capacities to come into being” (p. 17). This also fits with Grotstein’s (2007) contention that the ‘container-contained’ concept constitutes the unconscious template for attachment phenomenon.

The notion of ‘container-contained’ (Bion, 1962), found its purchase into other psychotherapeutic concepts. Starting with Winnicott’s (1958) construct of ‘holding environment’, although moving from being purely an internal phenomenon

into external and transitional dimension between two participants, and more recently Fonagy's (2001) concept of mentalizing and reflective functioning. Another concept prevalent in nearly all schools of psychotherapy that captures these mental and emotional experiences in the clinical relationship is attunement. There is an overall consensus amongst psychotherapists that therapeutic relationship in which being with a safe, attuned, and emphatic figure lead to development of positive feelings and make exploration and understanding of negative feelings about self and others possible. However, despite being amongst the most widely used ideas both in theory and practice, Bion's concept of the 'container-contained' has received virtually no attention from psychotherapy research (Grotstein, 2007). Therefore, it is of particular value from the research perspective that Bion's theory found support within accounts of the participants' own understanding of their therapeutic encounters.

**Secure attachment and attunement.** There seems to be an increasing consensus that therapeutic change is based, not only on cognitive factors such as awareness and insight, but also on the nature of the relationship between patient and therapist (Castonguay & Hill, 2012; Fonagy, 2001; Holmes, 2011; Mallinckrodt, 2000; Mallinckrodt & Coble, 2004; Mitchell, 1999; Weiss, 1994). Despite ample theory and research concerning the therapeutic relationship, there has been little empirical enquiry into the therapist as an attachment figure and even less research on the therapist as a developmental object as perceived by the client (Arthem & Madill, 2002; Knox, Goldberg, Woodhouse, & Hill, 1999). While researchers have typically explored adult attachment style in romantic relationships, some have begun to investigate attachment features in the therapy relationship (Weiss, 1994). However, previous studies on attachment to the therapist were predominantly concerned with clients who had received long-term psychoanalytic or psychodynamic therapy (Parish & Eagle, 2003).

Interestingly, similar experiences were reported by participants in the current study, irrespective of the treatment modality and length of treatment, which varied between medium to long-term. Typically reported were feelings of strong attachment to therapists, that gradually developed and intensified in the course of therapy. In some cases, there was a very strong need for a secure attachment from the onset of therapy: "I could only see her on Saturdays at the start; I felt unsupported without her during the week, and then she suggested, 'You know, you can ring me anytime

and if I'm busy I will call you back. Just leave a message". Therapist availability gave this participant confidence to continue working on her issues: "I had a lot of drive to keep going, and knowing all the time at the back of my mind she is there if I need her". Secure attachment also made it possible for the clients to express their dissatisfaction with their therapists and subsequently work through these difficulties. One participant spoke about how she got to the point when she was allowing herself to bring to the session negative feelings towards her therapist: "I could get grumpy, so, it was almost like, 'Oh, she can deal with it'". Given that attachments develop in the context of the therapeutic relationship, attachment theory provides a valuable contribution to our understanding of the relational aspects of therapeutic change. Echoing Bowlby's (1988) theory, the therapist, as perceived by the participants, served as an attachment figure, as a "secure base" from which the participant could explore their inner world. Aspects of the therapy situation that foster the development of attachment needs, include provision of a "secure base" from which the client can explore past and present experiences and the therapist being a trusted person to whom the client can turn in distress. Indeed, some theorists argue that the main reason that psychotherapy works is because it can function as an attachment relationship (Amini et al., 1996).

Participants frequently reported having strong confidence in their therapists: "straightaway I felt that rapport with him and the confidence that his methods were going to be of benefit"; "I always listened to what she said and totally put myself in her hands, 100 per cent."; "I had a person that I trusted and felt very confident in."; "...because I know I have always got her there. ..., it is like a security blanket."; and "I would never, never dispute anything she says, not that I have had reason to, but, you know, I put her in god status for me. I totally worship the woman." This can be seen, not only as an indication of a strong attachment, but also as an idealizing transference. This process can start very early in treatment, in some cases even prior to the first session: "I hadn't even seen her yet. I had only made an appointment....So, just knowing, even before I went to see her physically, I had that support". Another participant gave a description, indicating both strong attachment and transference: "You are a little person that is mine. That's all". There appears to be similarity between the concept of attachment and transference, in that, both refer to a strong emotional connection to another person, in which one repeats patterns of relating that are rooted in early childhood relational experiences. Analysis of current

findings is in line with literature on the existence of the interface between attachment theory and psychotherapy (Farber & Metzger, 2009; Fonagy, 2001; Mitchell, 1999; Parish & Eagle, 2003).

Attunement played a critical role in the development of secure attachment. Participants emphasized its significance to the process of therapy. Attunement typically manifested itself through the therapists' ability to connect with and respond to the subtleties within dyadic communication: "It was accurate reflections of my contributions in therapy, ...be those verbal contributions or also an accurate reflection of my body language and reactions in therapy"; and "I think she could read me quite quickly, ...It was more like, even energy, ...She would say, ...'I can see you seem a bit low today'". Attuned therapists were perceptive even to minute changes in mood: "The unique thing was that she had the Paul Ekman knowledge for reading facial expressions very, very, very well. ....every single twitch or nerve move, she goes, 'What is going on there?' She will catch it.". Other essential qualities of the attuned therapist included: emotional presence "she was really just there"; attentiveness conveyed by body language, "she would lean a lot, and she was genuine"; inter and intra-personal sensitivity, "I knew she was attuned with herself but she was also attuned in the interpersonal space"; emotional mirroring "when I was talking about something really emotional..., we had the same shared emotion"; and synchrony, "on the same wavelength, she was there, there was a certain ebb and flow. There was a certain agreement".

Holmes (2011) describes the role of the attuned therapist as a 'sound mirror' representing the client's self to himself. The therapist communicates to the patient that he or she has heard and felt his or her feelings, regulates their intensity, and implicitly or explicitly adds to this. All of these qualities were captured in the following description of the attuned therapist:

Attuned in ... really being interested in the relationship between us and whether there was anything that was causing me difficulty or I might have perceived negatively, always checking out those things with me. Her reflections were often really spot on and she tied in, say, things that were happening in the present day with related episodes from the past that really made a link for me, but it also demonstrated for me a real sense of caring that she understood the whole bigger picture about me, my background and my present. And the attunement to my in-the-moment experience ... if I changed or if I looked distressed but I hadn't said anything, just being able to sit with that and draw my attention to it. Yeah, so really being focused on me and my experience, and quite often being very accurate and having the bigger picture understanding.

Some participants provided an illustration of how the therapist's attunement skills enabled development of the same skills in the client. Attunement also prevented significant ruptures and allowed relatively unobtrusive reparation:

Again, largely non-verbal, I would say. I believe there may have been something in my tone, possibly body language as well. I suspect I was closing up in some ways ... but that I wasn't great at recognize ... I believe non-verbals and sort of pseudo-verbals like that are... how she recognized it, though that is just a guess. I never asked her how. And when I recognized it in myself, it would be quite similar as well, where if I recognized that I'm feeling more distant from you or feeling an urge to pull back from you or withhold from you, I would openly label that with her and then we would ... question around ... where that had come from. And that was probably the closest we came to disagreeing over interpretation or anything. We never had any serious ruptures ... throughout my experience. So it was usually, yeah, something relatively mild that would have me pulling back and when it was recognized, whoever recognized it would tend to handle it in a similar sort of manner.

**Experience of re-parenting.** Participants spoke about having a therapeutic experience resonant with the parent-child relationship. The therapist's interventions were often viewed as 're-parenting'. Participants gave expression to this notion in various ways including: "I feel that she is like a mother figure, but an educated mother figure that can really help me"; "the biggest learning experience for me was of being supported and cared for in a parental way, so the experience of that was very new and took quite a lot of getting used to"; and "It was like infant attachment which is something that you can actually take with you and tap back into at times".

The descriptions provided by the participants are in many ways analogous to the parent-child relationship; there appear to be similar functions within the therapist-client couple, including a security-provision in communicating intimate protectiveness. This was expressed by one of the participants in the following way: "I can handle this because I know I've got her there". Psychotherapy literature often conceptualizes these 'parental' aspects of the therapeutic relationship from the perspective of attachment theory (Holmes, 2011, Leiman, 1995; Slade, 2005). For example, Slade draws attention to the dimension of mastery achieved through the presence of a competent adult in charge of the play-space. This process was also evident in the experiences described by the participants in the current study: "I wouldn't want to do anything, unless she told me how to handle it"; and "It was modelled for me and then I developed it as a skill after practicing it repeatedly with someone else". Leiman's recognition that the therapist, like a parent, is responsible for providing space, both physical and metaphorical, where the client is directed to

tasks that are neither too easy nor too hard, was also evident in the experiences described with the current study:

I suppose, allowing me to sort of twist my way there in the beginning and her finding that point where she can go, and sort of guide me to where I should get, but in your own time and your own way. So, I think it is that sort of balancing the body and the mind, because those body responses for me have always been quite intense.

The significance of preoccupation with, and reliance on, the non-verbal signs of relating in the process of exploring and addressing psychological difficulties, was evident in the material provided by participants:

I was always looking, trying to detect behind her face, if she was bored out of her mind, and was too vigilant in trying to detect signs that she couldn't take it, she couldn't cope ... that anxious attachment, 'I'm too much for her.' If she even crossed her legs I would think, 'Oh good god, her legs, her knees are hurting her' .... I would always look for that ... and I had to accept at some point that she was with me.

Such sensitivity to the signs of rejection is resonant with the process of cross-checking that the child engages. The child seeks the accuracy and validity of their perceptions of the inside and the outside world with those of the care-giver, and in that way begins to create a picture of self and the world (Holmes, 2011). The same process occurs within the therapeutic dyad and can provide opportunities for re-working this early function. This fits with the Winnicottian concept of mirroring, which suggests that we learn about our inner world in a comparable way, using the caregiver's understanding to develop our own self-knowledge (Holmes, 2011). Therefore, if this function is activated within the therapeutic dyad and the therapist is cognizant of its meaning and significance, he or she can help the client gradually re-work these early 'templates' of self.

Another participant described the need for re-working or even establishing, for the first, time secure attachments. This excerpt is particularly significant, as it points to the depth of experience required to achieve meaningful change:

Not having had any strong attachment, having lots of bizarre things happen as a child, having this experience was - ... I think she described it a lot as re-parenting, and I didn't really understand that at the beginning, but I think I came to understand that right at the end. And I have done some seminars and workshops on the neurology of trauma and the right brain/right brain connections and that sort of stuff, which I think to me seemed a bit more of that sort of re-parenting and being able to have emotions more than just a smile. And then permission to have that sort of stuff and being in that space was, perhaps to me-that seemed more of that re-parenting, that going back to going, 'You are okay as you. Whatever you is, is' not 'You must fit into this box because this is you, and you are okay, but this is you because I know this is you.'



This description addresses another fundamental aspect of the re-workings of early trauma - the importance of recognition of the ‘true self’ (Winnicott, 1986). In this case, it was the therapist’s acceptance of the client’s core self, that provided a felt experience, which conveyed to the client a sense of deeper self. Both Winnicott and Kohut (1971) have stressed that the repair of self-injuries and development of a cohesive adult self can be reworked through therapeutic interaction. In the more recent ‘trauma-paradigm’ literature, this concept of the hidden, forgotten, dissociated core self is referred to as a ‘frozen baby’ (Papadima, 2006). Papadima stressed the necessity for a containing form of contact for the emergence of more intact and integrated self. This contact requires a specific type of relatedness between the client and the therapist, which generates in the client the state of mind called self (James as cited in Meares, 2005). According to Meares and Graham (2008), a fundamental aspect of that form of therapeutic exchange is an act of recognition that goes beyond seeing, into a much deeper form of responsiveness that evokes positive feelings which enables generation, or re-generation of selfhood.

Participants also emphasized the corrective nature of the therapeutic experience, which fostered development of functions lacking in the impaired parent-infant relationship:

It feels to me like a type of parental support that I haven’t had parentally, so it feels like developmentally, I have been able to pick up things and make up for things that I was missing from earlier experiences ... having someone who was supportive and caring and accepting and understanding, and it gave me a place to be in my own space and to have that own space, that validation of my space. Yeah, I guess to experience my own space and have my own space and be okay.

These accounts provide an optimistic view of the possibility of re-working, re-establishing, or even developing new functions within the self within a strong, reliable, and emotionally genuine therapeutic relationship. Reflections provided by the participants are akin to the depth, intensity, and fundamentality of the parent-child dynamics. The mother–infant literature suggests that, among other characteristics, a secure base parent also offers responsiveness, mastery, reliability, consistency, and the ability to repair disruptions of parent–infant emotional connectedness (Tronic, 1998).

**Internalization of therapist.** According to descriptions provided by participants the therapist functions as a witnessing and assisting figure that over time undergoes transformation from being present only in external reality to being

internalized. This is consistent with literature suggesting that the meaning-making interaction between the therapist and the client is one of the core functions of the internalization (Britton, 1998; LaFarge, 2014; Stern, 2002). According to these authors, the therapist's receptivity is necessary for the construction of an integrated, meaningful narrative, where internalization is about installing this receptive witness in the client's internal world. Internalization of the therapist was typically expressed in the following ways: "now I find that the therapy is just there. I just think it and do it now without really making any great effort"; and "now it is becoming second nature. I don't actually have to think about it anymore. I've changed so that it is just there". Another participant said: "I would get myself to the stage of something and then I would hear her voice coming from afar and I was thinking, 'I know what she is going to say'".

Participants commonly described their therapists as trusted and receptive figures: "I thought I could go to her and I could just let everything go ... so by the end of it I felt really good, and now, every day used to be a struggle, now it is not. I can pretty much breeze through things". This is also about internalizing the therapist's attitude and skills that subsequently can be practiced in the outside world:

... feeling accountable to someone else for my actions, for the decisions I was making, for my views, was something I found beneficial. So, in a very simple way, having someone who would check whether or not I continued to exert the effort to work towards different interpretations of myself and my world was something I found helpful in therapy and something I feel like is a skill of sorts. It was modelled for me and then I developed it as a skill after practicing it repeatedly with someone else .... somehow having another person there accountable helped me to be responsible in a different way.

Previous studies illuminate these findings. Clients who perceived their therapists as reliable attachment figures reported greater occurrence of internal representations (Geller & Farber, 1993; Knox et al., 1999). Some participants acknowledged continuing the therapeutic process when not in the session; they were able to maintain this connection by having internal representations, which typically enabled them to continue a therapeutic dialogue with their therapist, when not actually in their presence. In these instances, essential ingredients of a secure base, such as on-going intimate proximity, availability, and being 'held in mind' when absence occurs, were also evident. These findings are echoed by previous research on the clients' experience of the therapeutic process and its continuation outside of the session (Knox et al., 1999; Orlinsky, Geller, Tarragona, & Farber, 1993).

The current study shows that transitional objects were also part of the process of internalizing the therapist as a ‘good object’:

So little things like offering, for example, if she was going on a particularly long break and depending on how intense the therapy was, sometimes she might offer me a little memento or something from her office ... just to carry or keep with me as like a transitional object.

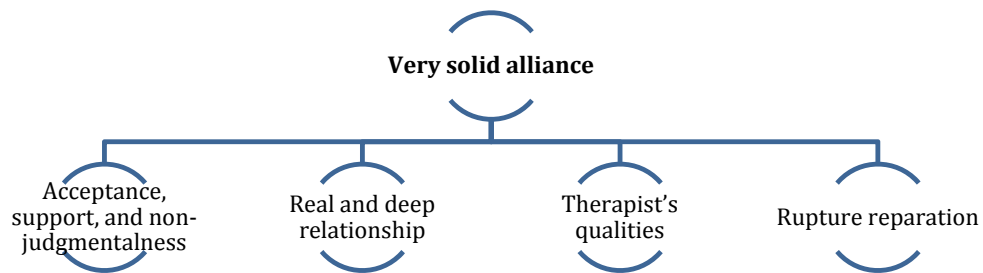
This excerpt shows that the internal representations can originate from a transitional object, which provides, in tangible form, a source of support between the sessions. Such a transitional object, described by Orlinsky and colleagues (1993) as “psychological connective tissue between sessions”, facilitates the development of internal representations of the therapist and recreates affective and cognitive components of therapy. Findings from this and previous studies (Arthen & Madill, 2000; Stolorow & Atwood, 1991; Knox et al., 1999) show that internal representations, not only provide a reparative function, but are also ubiquitous to the therapy process.

Overall, descriptions provided by the participants emphasized the importance of the therapist to the client, stressing the centrality of attachment and attunement to the therapeutic process. The results show that the relationship that forms in longer-term psychotherapy has many qualities of an attachment relationship. This is in line with Bowlby’s (1988) assertion that time spent together is the factor most likely to foster an attachment relationship, a notion confirmed by other studies (Parish & Eagle, 2003). The participants in this study provided numerous accounts of how they looked up to their therapists, even idealized them for periods of time, and how they found them emotionally attuned and responsive. They reported seeking proximity to their therapists, reaching out to them in time of distress, and in their absence, often evoking some form of their representation. All the participants in this study had developed some level of attachment to their therapists; many also regarded their therapist as unique and irreplaceable, and experienced very strong feelings about them. Thus, these therapy relationships and the role assigned to the therapist had a striking resemblance to developmental functions and strong features of attachment, as identified in attachment literature (Duquette, 2010; Fonagy, 2001; Lyons-Ruth, 2006).

### **Very Solid Alliance**

Despite various definitions of the therapeutic alliance, there is a consensus amongst researchers and theorists that for an alliance to be effective it needs to have

the following ingredients: (a) shared goals; (b) consensus on means, methods, or tasks of treatment; and (c) an emotional bond (Bedi, 2004). Results from the current study are largely in line with this definition; however participants placed particular emphasis on the relational aspects of the therapeutic dyad. These were captured in the following themes: acceptance, support, and non-judgmentalness; real and deep relationship; therapist's qualities; and rupture repair.



*Figure 15.* Very Solid Alliance.

**Acceptance, support, and non-judgmentalness.** Generally, participants recognized the experience of being accepted, supported, and not judged as indispensable aspects of therapy: “[without the acceptance] I wouldn’t have got started otherwise. I had been to other therapists before and didn’t feel the same kind of acceptance, I just felt totally judged”. In various ways, all participants stressed the centrality of these factors: “the most valuable part of it to me was being accepted and not judged, and supported, ...feeling I could be honest and open and that the therapist was on my side”; “it was very implicit—that you are not that bad, ...it was very strong sense of acceptance, ‘It’s okay to be not okay.’” ; “I really felt she was so warm and accepting about whatever was happening without any tinge of judgment whatsoever”; “friendliness and compassion, and the non-judgmentalness”; “the acceptance in that place, they were powerful things”. Some participants described the experience of being accepted as a foundation for internalization: “they accepted me, then it helped me to accept myself”; “being accepted and not judged and forgiven, it helped me ...forgiving myself and accepting myself”; and “non-

judgmental acceptance ... knowing that they kind of like you .... There must be something about me that is likeable”. Participants recognized that while they often had a strong tendency to judge themselves, the therapist’s non-judgmentalness made them examine they own tendencies: “ [it] helped very much. It made me look at why I judged”. One participant described the workings of these qualities in the following words:

Feeling like a person is on your side and feeling like they are accepting you. I come back to those words because that is the core of it for me, just that acceptance, non-judgmentalness, and that they are on your side, even when perhaps I didn’t think that I should have had someone on my side. You know, their ability to slowly chip away at that, the hardness and the guilt.

Here, the importance of self-forgiveness and dissipation of guilt is emphasized as central to psychological recovery. Many participants implied that the reduction of guilt was one of the aims of therapy.

Participants commonly acknowledged the significance of support in the process of change: “she gave me a lot of support because it was really frightening to make some of the changes”; and “just the effect of support in what you think is right to do ... makes you stronger in doing those changes - ... just those extra supports in time of need that really helps”. One participant referred to the experience of being supported as being “positively regarded”, that he explained as: “It seems almost childish to say it, but, having someone cheerleading for you in some ways and believing in you in-that respect I found helpful”. For another participant, being supported meant being psychologically “affirmed” by the therapist: “I found my therapist’s ... affirmations of my parenting ... my position as a friend ... I did feel much more positively about my psychological competence”. Being offered another point of view without being judged was also strongly emphasized as change promoting: “being able to talk to him and getting, not so much an opinion, but a view that wasn’t going to be judgmental or anything like that”. This type of support differs qualitatively from the ordinary form of assistance “because it is quite different support from what you might get from your sisters or your friends because it is still a bit distant and is not as personal but it is very helpful”. This is further emphasized in the following statement: “the acceptance, the not offering short term reassurances”. This participant understood that reassurance and short-term solutions often imply a lack of a deeper level of acceptance. Having a consistent experience of support led to its internalization: “I always felt like there was somebody there,

who would just listen, and I could make whatever decisions I want and I would be supported through that without judgment .... it was really profound. It was actually really quite an intense feeling I was left with at the end of that”.

In some instances, acceptance, support, and non-judgmentalness fostered a sense of belonging: “I think a feeling of belonging and a feeling that no matter what I said or did, I wouldn’t be judged”. The experience of being accepted also facilitated a process of self-reclaiming: “it just give you back yourself .... I think it is more about acceptance really. I really do. I think it is about accepting things, and accepting all of you as you are, not as a person that has got this problem or that problem”. This statement indicates that acceptance evokes a deeper process of expanding and reclaiming disowned aspects of self. There was an overall consensus amongst participants that being in the presence of an accepting and non-judgmental therapist was change facilitating: “feeling very at ease, and it allowed me to sort of open up and actually get further, than putting up a wall”. Another way of expressing how such attitude facilitated change included:

Helpfulness of the unconditional, a sort of positive regard where it was something that was very difficult for me to say and it was received and not judged usually in those situations....I believe people can express deep emotion and find catharsis through that in therapy in large part because of the bond they feel with their therapist.

**Real and deep relationship.** Typically, participants reported that a deep relationship was essential to remaining in treatment. They also valued it over any specific therapeutic technique: “Do you know what was much more important to me than a frame of reference, is the relationship”. They also spoke about having the experience of a very unique and intimate therapeutic relationship, in which they felt understood on a very deep level:

Her, not experiencing them with me, but as close as someone can be to experiencing my experience or understanding my experience. So ... I think that is as real as I can imagine. I think it is as much understanding as I could expect anybody to have of my experience. I didn’t have to have any pretences with her. I didn’t feel like I needed to protect myself or I couldn’t disclose. I think she was the first person that really understood.

The dimension of reciprocity was recognized as part of the deep and real experience of being understood: “So I know that the things that we shared touched her, not in a detrimental way, but in a genuine way .... her caring was genuine and she managed to demonstrate that”. The sense of being understood comes from being ‘thought of’ by the therapist, who is having a real experience of being with

themselves while being with the client and is able to convey it through the act of understanding. The role and significance of the real relationship to positive treatment outcomes have been previously researched (Blatt & Shahar, 2004; Duquette, 2010; Fuertes et al., 2007).

Descriptions provided by the participants stress the experience of real human interaction as change promoting:

I think the most helpful thing was the human interaction .... obviously gradually over time, allowing the therapist to see more and more of my sort of more human primitive shameful side, the part that maybe only one or two people would ever see and ... her not recoiling in horror and going, 'Oh, that's so horrible!' or 'How could you think that?' I mean, we know intellectually, but until you have actually experienced it, it can be very powerful.

Recognition that a real relationship is necessary to bring about change comes from the experience of being seen in a real and often vulnerable state. This resonates with the research findings from The Boston Change Process Study Group (BCPSG, 2010); they also draw attention to the fact that for such experience to occur, the therapist needs to be real and genuine: "In the real relationship the emphasis is on the kind of interchange in which the therapist experiences him or herself as genuine, more 'himself' or 'herself' as distinct from a way dictated by feeling in the role of the therapist" (p. 326). One participant expressed this in the following way: "I think that came across, that realness of it. ....it is not an alliance. It is just the relationship. It is her being very real in that relationship and being her and being ... accepting of her strengths and weaknesses ...". Findings from the BCPSG confirm that this real interchange must involve "a specific personal aspect of the therapist, and it occurs, often spontaneously, in some form of affective communication between therapist and patient" (p.326).

This concept of a real and deep relationship is expanded by the notion of 'knowing', in that one of the aspects of being deeply understood, for some, came from an intuitive sense that the therapist had some real deep knowledge: "I think that notion that people come to you because you know. I don't know how that works"; "... although I was drawn to her and I don't know how that happened". It is not intellectual knowing, but one that comes from experience: "and that was why it was so real .... this was experiential"; "she knew what it was like for me because she had had the same experience". 'Knowing' was also understood in the context of a very intimate knowledge that the therapist develops about the client; this allowed

space for non-verbal communication which gave rise to moments of deeper understanding: "... because she knew so much about my life ... and so that was really important to understand that I could tap into something deeper inside me and make me okay without having to tell all that happened".

The trust in therapy and the therapist formed one of the central features of a real and deep relationship: "I have trusted her as much one human can trust another". Such strong sense of trust required time to develop: "she is here for the long haul, she is not going to back out, get cold feet, give up when it gets too hard". Only when solidified, this trust was experienced as a "real sense of, 'we are both in this together'". Trust was the catalyst for the workings of therapeutic couple that were characterized by a very deep form of exchange, a real meeting of two people, a real connection:

That relation ... is like this energy between you which is really interesting because I have had a couple of different perspectives. One was that there were three energies in the room. There is you, there is the therapist and there is the energy between you. And another one where it is almost like there is one energy which goes all the way around you, and perhaps that is where you end up getting to, to where this energy can expand and surround the both of you because it is quite a unique relationship. It is very intimate and very unique and very sacred.

The feeling of being genuinely liked by the therapist also formed the foundation for therapeutic change: "After a while she just liked me and that was pretty revolutionary"; and "It felt like she actually really liked me as a person, not just as a money maker. It wasn't a performance". The essence of the authentic personal engagement that developed between the client and her therapist is illustrated in the following segment:

It feels like someone has touched my soul as no one has never done that before, and has actually touched it and said, "It is okay. It's not just okay, it is actually beautiful. It is good. It is just right the way it is." .... when she left ... she said, 'that face-to-face connection will end but the emotional and spiritual connection will never end', and ... it felt so true .... it was a definite connection for me. It was a really important one to have.

One of the explanations as to why such deep personal connections can leave a lasting impact comes from object relations theory that focuses on how relationships between individuals are represented internally (Grant & Crawley, 2002). According to this theory an inner mental representations constructed based on the interactions with others form the template for subsequent relationships including expectations and wishes of how others will respond to the individual's needs (Grant & Crawley,



2002). Thus, the mental state of the individual depends on the state of the internal object, in that, introjection of and identification with a stable good object is crucial to the ego's capacity to cohere and integrate experiences (Brenman, 2006). The above excerpt can be seen as an illustration of the process of the recovery of a good object, in that the therapist who is experienced as genuinely accepting and loving, can be introjected, identified with, and internalized so that it is subsequently felt as existing within the self.

As in object relations' theory, other approaches including cognitive behaviour therapy, attachment theory, gestalt therapy, and schema therapy also view internalization of therapist and therapeutic interventions as curative. For example, one of the techniques central to schema therapy, known as limited re-parenting encourages client's dependency on the therapist who provides regulatory function on the affective and cognitive level which over time becomes internalized by the client (Young, 2003). This technique focuses on assisting client in internalizing healthy adult mode of functioning that is achieved by having therapist to respond to the client's early dependency needs and by meeting them laying foundation for healthier and more independent construct of self (Young, 2003).

Participants in this study provided numerous examples showing how authentic personal engagement promotes change and personal growth. These descriptions centred on realness, intimacy, and depth, and provide something of an anatomical structure of what it 'feels' and 'looks' like to be in a real therapeutic relationship that can be internalized. The kernel of this process, as identified by the participants, is that communicating with words was never sufficient; they needed to be given an experience of it, in order to internalize it. It was not just 'knowing about', but the 'knowing it', which came from the felt experience generated between the client and the therapist, that led to change. This is in line with previous theorizing and some research findings, which emphasize that the real and deep relationship is "a specific modality of treatment that is both necessary and sufficient for change" (BCPSG, 2010, p. 203).

**Therapist qualities.** The therapist's qualities were considered central in terms of helpful factors. These included competency, warmth, realness, perceptivity, and flexibility. Participants typically acknowledged the value of the therapists' professional skills and knowledge: "she gave me good information"; and "I think she had a very strong sense of the frameworks she was using and the tools she was

suggesting, and she presented them in a sophisticated nuanced way, not as a blunt-edged ... ‘This is the problem. This is what you do’. This excerpt gives insight into the meaning of competence as something that goes beyond providing information; it communicates knowledge and skills that have been truly understood and subsequently conveyed to the client in a personally meaningful way. A competent therapist is also someone whose solid knowledge-based foundation allows him or her to be ‘free enough’ to listen to the client:

You have got the confidence to stop worrying about what is the next thing you have got to say, and actually listen to the client .... If you give your presence to the client, you can feel that as a client. You can feel that the person is not thinking of ‘What is the next question?’ or ‘What is the next clever thing I can say?’ or whatever. They are just trying to listen to you. And sometimes they have spaces too, where they don’t know what they are going to say or whatever, but at least you know they have listened to you and occasionally that is when I think something can pop into their head that is useful too that they can say which will trigger something else in you.

What is significant in this quote is the fact that the client can feel the difference between someone who is fully engaged with them and someone who is cognitively preoccupied with the right way of responding.

Competence was also seen as the therapist’s ability to “comprehend issues that I was going to be dealing with, without me having to explain everything in detail”. Being competent also meant being “willing to be wrong”. Linked with this is the capacity to assist the client to discover their own truth, instead of ‘educating them’ and needing to know too pre-emptively where the links are:

The therapist allowed me to talk and organize my feelings through talking and didn’t interrupt and sat out the silences with me. That was very helpful. As a client you feel that you are the expert of your own experience, so they can test theories out and make suggestions, but always sort of say, ‘How does that sit with you?’ Yeah, I think that is important, so that you feel that you are not being educated. I mean, you feel as though you are two adults kind of exploring the possibilities.

The therapist’s ability to guide and re-focus the client by “pinpointing places to start” and to sustain direction and purpose was also valued:

But she wouldn’t let you go on doing the same old stuff month in and month out. So I didn’t figure she was just here just to take my money and whatever. There was progress and I felt I did move on. If she felt we had come to a bit of a block and I wasn’t quite ready to do it, she would say, ‘Look, that’s okay, we have done enough. You know you can come back when you are ready’.

Another component of professional competence was the therapist’s ability to be a very good listener: “she was very grounded, and she listened very well”; and, she was an “acute listener”. Part of the same dimension was the ability to remain curious

and interested: “He was never bored .... He may have been bored, but he never projected that he was bored with the story or the information”, and “curiosity ... just the sense that this person is a partner investigator, that they are interested and that we are going on a journey together. I think I am pretty sensitive to disinterest in anyone really, so I find it useful when the therapist is awake”. The therapist’s acute listening also prevented diversions and assisted the client in staying on task.

Significant value was also ascribed to the therapist’s ability to be warm and real. Some of the characteristics that gave the sense of warmth included: “calm and relaxed”; “approachable and caring”; “kind and friendly” with “really nice soft voice”. Therapist’s ability to make the client feel safe and comfortable also enabled “freeing of thoughts, freeing of emotional responses and it ultimately facilitated insight”. Realness was interpreted as a “mutuality of interaction”; “sharing the same reality” in which therapist shows responsiveness to the client as another human being. This was often expressed in extra-therapeutic acts such as providing explanations in instances when the therapist was going away or offering an umbrella, which were experienced as a very personal gesture that meant an enormous amount. Mistakes made by the therapist also constituted valuable element of the realness: “even if she contributed something that wasn’t helpful, it was still real. It was still that she was demonstrating that she was human and she was making an effort and trying to work with me, and that really matters”. Times of laughter were commonly viewed as real and therapeutic moments as they required the therapist to let their guard down and have an honest reaction:

Mm, laughing about the predicaments we find ourselves in and being able to relate to it as people, yeah, I find that helpful from a therapist .... it is soothing, it makes you feel like you are not under investigation, that that person knows where you are at; they have been where you are at.

Realness however, was not seen as constant state, but instead as a quality which can fluctuate in its intensity.

Participants attached significant value to the therapist’s capacity to be perceptive and flexible in responding to their needs: “So she had a work ethic, but she didn’t bow down to... fear, like, ‘Oh, I cannot do this because’ you know. That was exactly what was helpful”. These characteristics were seen in a willingness to respond to the client as he or she was in the given moment, without prematurely putting it into some structure:

... to go in there with this, ‘I know somewhere what I need, but there is no way I can see it, I can think it, but I know that I need to do this now. I don’t know what it is I

need to do as such.’ And be allowed to have, as you said, that chaos and allowed to sort of tease my way through it and just see like the murky waters until you find these little whirlpool things that maybe go around until they merge into each other, and allowing me the space to do that without having to almost justify all that, and how long actually this would take. ‘This can take as long as you want.’

Another facet of flexibility was reflected in the therapist’s willingness to forgo some rules, along with assessing the situation on the individual basis:

There was something about her, where she didn’t have a strong firm sense of rules, you know, ‘We have this many sessions and then we are finished’ and I remember pointing out to her I couldn’t see her one more time that year because I was exceeding my sessions, and she just shrugged her shoulders like, ‘Hah! Rules are rules, but they are there to be broken; we have some control.’ I really liked that. That was about the middle and it was a sense of she was not in any way rejecting me when I was expecting it, and we had a lot longer to go and I didn’t know that.

**Rupture reparation.** A rupture in the therapeutic alliance is defined as a tension or a breakdown in the collaborative relationship between the therapist and the client (Safran & Muran, 2000). Some participants described the nature of an alliance rupture and the significance of its reparation. Findings indicated that the ability to repair ruptures was strongly determined by the quality of relationship between the therapist and client. Mistakes were bound to happen, but did not cause significant ruptures: “Even though she asked me ridiculous questions before .... We had a laugh and that was fine. She had a license to make mistakes”. While ruptures inevitably occur in every therapeutic relationship, it is the strength of the alliance that predetermines the degree of reparation. Psychotherapy research consistently shows that the quality of the therapeutic alliance is a robust predictor of therapy outcome, irrespective of type of treatment (Colli & Lingardi, 2009; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Safran, Muran, 2006).

Research on the alliance seeks to identify the factors responsible for the development of the alliance as well as the processes behind the rupture reparation (Safran, Muran, Samstag, & Stevens, 2002). The current study shows that part of a very strong therapeutic alliance was trust in the therapist’s skills and having some agreement about the suggested method of treatment. In order to implement changes, participants had to have some level of trust in the therapist’s competence and skills:

My initial reaction was, ‘Well, how does that work? I don’t understand.’ And he sort of explained it and I sort of thought, ‘Well, okay’. I accepted it. I didn’t really fully understand how it worked .... I thought, ‘Oh well, I trust that he knows what he is talking about, so we’ll try it and see.

Similarly, another participant recognized the relationship between trust and respect for the therapist's skills and implementation of suggested changes:

Immediately I felt very comfortable with her, and I think it was about our compatibility .... although in a dependent relationship, I felt respected. And she gave me lots of positive feedback about my success and all that sort of stuff too. Yeah, from the very beginning I felt very positively towards her and willing to listen and willing to try things that perhaps I wouldn't have been willing to before .... I think when it was first suggested I thought 'That is not likely to be very effective' or whatever, but I think I trusted her enough to try it, and I think for me that combination of trust and respect, I thought, 'I am paying her a lot of money for this encounter, she is a highly skilled person, the least I can do is to try it' you know. So it was respect for her position and knowledge and skills that allowed me to do it even though I thought, you know, 'That is too easy; it is too easy just asking people what they want'.

Ruptures in the alliance consist of disagreements about the tasks and/or goals of therapy and strains in the therapist-client bond (Safran & Muran, 2006).

Participants in this study tended to describe the dimension of strains in the therapist-client bond, rather than task and goals. This is probably related to the fact that ruptures within tasks and goals would typically occur early on in treatment and if not resolved would lead to premature termination. Since all participants had completed longer-term therapy (on average 2 years of therapy), it is only reasonable to expect that on the whole their goals and tasks were compatible with those of the therapists. Despite this being a rare occurrence, one of the participants provided an example of a rupture within the task dimension:

When I got angry with him—...—he didn't react in a way in which most people would react if they get a bit yelled at or they have someone getting a bit huffy or a bit defensive. He just sort of said, 'This is what is happening. This is why I am doing it.' And there was a sense of realness in terms of, 'He is not personally offended by me getting upset about it.' It was okay that I pushed back on him. Instead of him always pushing me, I could push back on him and say, 'No, there is nothing there for me. Just stop it!' So, that was also quite real for me.

In this instance, the therapist believed that it was important to spend time reviewing and making sense of certain past events, but the client had more of a here-and-now focus. This excerpt further shows, that it was the way the disagreement was handled by the therapist that allowed the client to voice her opinions and reactions, without fear of being rejected or punished. These findings resonate with current research on alliance ruptures (Safran, 2013), which shows that if disappointment arising out of the moments of discrepancy in the therapeutic relationship can be expressed and then thought about and discussed, it will result in psychic growth. Research also shows that rupture reparation requires heightened sensitivity and attunement on the part of

the therapist, particularly as clients are often reluctant to show negative feelings towards the therapist (Rhodes, Hill, Thompson, & Elliot, 1994).

More commonly, however, participants provided examples indicative of a strain in the bond dimension, such as sense of being misunderstood or patronized by the therapist:

I remember at the time that .... I was extremely uncomfortable with that question, and I remember reacting adversely to it. .... I remember at the subsequent session he commented about my reaction to that and apologized that I may have been unsettled, or whatever the words, but ... he acknowledged that that question had stirred me a great deal. And I guess equally I appreciated that he acknowledged that. So ... that was actually quite helpful at the beginning I guess in sort of developing a sense of trust for me.

The therapist showed the ability to respond in a non-defensive way when acknowledging the patient feeling criticized. Clarifying misunderstandings can also lead to rupture-repair. Here, the therapist notices that the patient seems withdrawn and initiates an exploration of what is happening in the here-and-now of their relationship:

Usually fairly explicit, usually a recognition of the distance or of me having difficulty in the session, and an enquiry into what had gone on there, which through sort of question and answer would eventually arrive at the point of recognising roughly where it started in the session and then realising that there had been a misinterpretation. And so, in that way it was usually helpful to see that sometimes she hadn't misinterpreted, sometimes she had, but either way it was helpful to then clarify what I had meant, and move on from there. That was usually how it worked.

Participants reported that the alliance was repaired through the therapist's actions including: the therapist acknowledging his or her mistake and the impact this has had on the client; the therapist modifying his or her behaviour in a way that felt meaningful to the client; and the therapist providing direct guidelines or engaging in collaborative problem solving with the client.

Safran and Muran (2011) emphasize that rupture reparation is not concerned with eliminating misunderstandings, but processing feelings associated with them and finding ways to talk about them. This process is illustrated in the current study. Therapists were able to non-defensively acknowledge their mistakes, apologize for them, and explore new ways of handling difficulties. Therapists, together with their clients, were able to reflexively think about ruptures and this, in turn, strengthened the therapeutic bond. This notion is captured in the following excerpt:

There was the occasional time when she just didn't get what I was saying or she would say something that I just felt like wasn't enough. But on the other hand, those were also the moments, those little ruptures, were the moments where we would

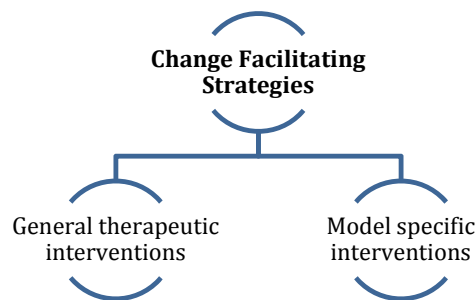
always come back to a pattern. So that is sort of what I mean by, long-term there wasn't really anything unhelpful, but in the short-term there were these things that felt really unhelpful, but that repair of the rupture again and we would be looking at that, could actually end up being the way forward.

Safran and Muran describe this as change promoting, as it enhances the client's capacity for self-awareness and negotiating skills in intimate relationships.

A high degree of severe ruptures was not evident in the data from the current research. This was most likely related to the fact that these clients were in longer-term therapy with an overall positive outcome. This data indicates that ruptures were often skilfully resolved and therefore experienced by the clients as deepening their relationship with the therapist as well as their own self-knowledge. While replicating previous findings, the current study strengthens the significance of the relationship between alliance rupture and therapy outcome. Previous studies typically obtain their data from post-session impact questionnaires which directly asked about the importance of the alliance rupture (Muran, Safran, Samstag, & Winston 2005) while in this study ruptures were acknowledged spontaneously by participants.

### **Change Facilitating Strategies**

Participants viewed techniques and strategies as valuable when they were acquired within the context of a personally meaningful and emotionally deep therapeutic relationship. These included general interventions as well as interventions specific to a particular model of treatment.



*Figure 16. Change Facilitating Strategies.*

**General therapeutic interventions.** There were common therapeutic interventions recognized by all participants irrespective of the model of treatment. One of the most valued and essential interventions was the therapist's ability to focus

on the client, listen attentively, and provide understanding: “I certainly have never been allowed to really speak as such. So just being actually listened to is really quite intense anyway”. Amongst other frequently mentioned therapeutic interventions were various ways of working with affect, including naming feelings: “someone being able to put words to my experience and feelings in a way that I was struggling to”; validating and normalizing feelings; experiencing and intensifying feelings: “she allowed me to maintain the rage”. Participants also emphasized various therapeutic interventions that enabled them to learn about their problematic behaviours and how to change them. These strategies consisted of: modelling behaviours for the client: “I think that the behaviour being modelled in that way, when it works ... results in that sort of experience for the client”; reconsidering patterns: “my therapist would have said to me about 40 times, but it often took a while for it to go... ‘there it is’ or ‘oh, I’m doing it again’”; summarizing and explaining: “with one sentence she just explained it, and I was excited because I never would have thought that”; questioning: “being active in asking”; reflecting and repeating back to the client: “I found it helpful when my therapist would repeat things that I said so that I could actually hear myself back, the way that I talk, the language that I use about myself, about life”. The significance of repeating back to the client is illustrated in the following excerpt:

... being in your own brain you are so used to your self-talk, that you become desensitized to the actual meanings or the gravity that you put on certain things, so hearing it back I can understand the nuances of my attitude towards myself ...

Reflecting was universally recognized; participants described it in terms of the process through which readiness to change developed:

She just allowed me to kind of talk myself in circles and I started hating the sound of my own voice and wanted her to make me feel more interesting and she wasn’t doing that very much. And then she reflected that need in me to be reflected or to be validated by her.

Here the significance lies in allowing space and time for the material to make itself ‘visible’ to the client before any insight could be generated.

The therapist’s ability to listen, understand, and convey understanding in a clear, succinct manner was experienced by all participants as very helpful and ultimately change promoting:

So I would be waffling on for ages and she would give me a sentence back that summed it up. I couldn’t quite put it into words, but she could. So that was sort of where I felt really understood. I think it is what brings about change. It is probably the point that change happens. I think that is the point where the change comes about, when someone understands what you are trying to say and particularly if they can reflect it back to you, it helps you just



to create sense of everything. Suddenly everything makes sense. Rather than just talking about things, you are experiencing it.

This excerpt provides an evocative illustration of factors that promote change. In this description, the emphasis is placed on the moment of insight that comes about from the experience in which meaning is co-created. There is a real meeting of two people who are doing more than ‘just talking about’, they are ‘joining in’ to understand.

Essential in promoting change was the therapist’s skill of questioning. Questions were seen by all participants as central to the process of self-exploration, in that the right questions were able to maintain focus, bring things into the consciousness and help the clients see how they felt and how certain things were effecting them: “I know there is a ceiling above my head but I have never really looked and acknowledged there is a ceiling above my head”. This process often consisted of questioning the source of one’s own thinking: “it was helpful to question the automatic thoughts I had about who I was or what I should do”. According to participants, these questions facilitated the deepening of the process by “drilling down and then looking at what’s going on in the whole”. The objectivity of questioning was also useful: “based firmly out of rationality rather than self-interest or a desire to make me feel better necessarily”. Participants emphasized that it was curious questioning, without judgment, that generated further self-exploration: “I would have to think, ‘Why?’... because she was curious”. One participant said that curious questioning made him “really think and attend to the issue”, but interestingly he also recognized that he “often couldn’t answer question because [he] just didn’t know the answer really, and that type of questioning was sort of the basis for progress in recovery”. He seems to be saying that real progress in self-discovery lies in illuminating the fact that there are aspects of self previously unknown to the client. Overall, facilitative questioning inevitably led to broadening and developing new perspectives. It was compared to “breaking down defences” or “breaking down walls”.

Irrespective of treatment modality participants spoke about the significance of being assisted with naming their emotional states. This process of naming and putting into words elusive and difficult emotional states assists in forming links between affects and memories, resulting in integration (BCPSG, 2010; Bion, 1963). They also described as helpful interventions which facilitated greater understanding and control over their own affective states. This understanding seemed to be partly

facilitated by experiencing emerging feelings with minimal constriction and in the presence of the supportive therapist. Of paramount significance were therapist's assistance in recognition and acknowledgement of the feelings, followed by an exploration of these feelings. Being asked to "slow down", "look at", and "acknowledge" emotions, facilitated this process. Participants also indicated that processing of affect depended to some degree on its elucidation: "there were some evocations of emotions ... and she didn't rush it"; "she would take me deeply into the affect and keep me there and encourage me to be breathing and stick with it and process it and stay with the discomfort". These forms of affect processing and regulation are categorized within psychotherapy research as typically involving: (a) activation of maladaptive patterns; (b) creating inconsistencies by introducing corrective information; (c) focusing the client's attention on the emerging inconsistencies to enable movement towards new patterns of thinking, feeling, and behaving (Castonguay & Hill, 2012, p. 73).

Findings also indicated that this process was activated by the therapist's validation and intensification of the ascending affect which, in turn, led to further exploration and ultimately to separation of the event from the emotional reaction. This is in line with Schore's (2011) assertion that affect regulation is an implicit process central to change. He claims that it is only through the experience of an affect and subsequent separation of a stimulus from its response that the process of modulation and modification of affective responses can take place. For this process to be accomplished, the client needs to be assisted in thinking about feelings, that is, the raw feelings need to form a thought that does not exclude feeling, but reflects it.

Participants emphasized experiencing affective states in new meaningful ways. It was the interaction between the therapist and the client that facilitated an important emotional link:

There was this incident and when I talked with her I realized that it was traumatic for me. Like, I could feel my body go, 'Huh!', like, that whole tight knot that went in when that image and the thought came at the time, and she said, 'It seems like it was traumatic' and I was like, 'Yeah.' And I was like, 'Gosh, yeah!' and once I felt it I broke down. I was like, 'My gosh!' You know, it was really that difficult for me. It is just like I didn't feel that intensity until in the four walls and with another person and you are just talking nothing but this, yeah. I mean, therapy changed a lot. In a way it gave me a headache when I left sessions. I mean, I was like, 'Ooh!' but in a good way.

This emotional experience of knowing differs qualitatively from 'knowing about emotions' (BCPSG, 2010). Bion (1962) describes the latter as an expression of

unprocessed emotional experiences, stored as undigested data which is often expelled or projected and cannot be used for thoughts and learned from. These unfelt emotions, for example, grief that is not felt, or pain that is not suffered, in order to be processed and comprehended, require a function that enables meaningful emotional experience (Bion, 1962; BCPSG, 2010). Bion's theory postulates that in order to turn unfelt elements into felt ones, the therapist needs to exercise this function within his or her personality and provide a containing mind for the elements discharged and projected by the client. This concept originated from Kleinian theory that emphasizes the importance of internalization of a maternal container, that accepts, manages, and transforms anxieties and other negative affect (Bion, 1962; Segal, 1974). Similarly, the process of experiencing previously unfelt affect could be facilitated by the therapist's containing function, that enables the client to transform his emotional experiences. Segal explains process of containment in the context of an infant's relation to his mother:

When an infant has an intolerable anxiety, he deals with it by projecting it into the mother. The mother's response is to acknowledge the anxiety and do whatever is necessary to relieve the infant's distress. The infant's perception is that he has projected something intolerable into his object, but the object was capable of containing it and dealing with it. He can then reintroject not only his original anxiety but an anxiety modified by having been contained. He also introjects an object capable of containing and dealing with anxiety...the mother may be unable to bear the infant's projected anxiety and he may introject an experience of even greater terror than the one he had projected (pp. 134-135).

Other commonly used interventions included observing, reframing, offering other perspectives, and providing feedback and explanations. Participants found reframing and offering another perspective to be change promoting: "Often I would be seeing it as my fault, my issue, and she would talk about ... how other influences or other people, so sort of getting the message that this actually isn't all me. It is not all my fault. It is not all something that I have created". Participants often stressed the value of having someone who could provide them with another, more realistic perspective:

Having another observer in the room whose got skills and who can hear what you say and put it back to you in a different way, or make a suggestion about what they have heard, which may or may not resonate, but that is very helpful.

Such interventions were experienced as perspective broadening: "all I am seeing is what is in there, and he is seeing the whole thing". One participant described the process of developing a more realistic perspective:

... having a person with another perspective watching my life as it was and watching my past as it was, was helpful for me, as it allowed me to see a broader range of possibilities. I feel ... when I started ... and throughout ... I would run into personal limitations when it came to viewing what would be possible for my life; and so having a second perspective there was helpful in that way, without necessarily directly suggesting possibilities, simply questioning what I saw as possibilities broadened my view of myself, my view of other people, my approach to work .... The belief, that the perspective I got was objective, was, ... what made this more helpful than friends opening up other perspectives.

In some instances, therapists used their own experiences as a way of providing the client with another perspective. Participants reported finding such interventions helpful when it was done selectively. In addition to this, the opportunity to safely explore and rehearse their own thoughts, fears, and desires was valued in therapy. In relation to difficult questions and significant decisions, one participant spoke about the role of therapy: “therapy gave me the opportunity to explore that without having to follow through with it, and to put it out on the table without being held responsible yet for it. So that was actually very valuable within therapy”.

Participants reported seeing real progress when applying practical strategies outside of therapy; it felt like “getting somewhere as opposed to stagnating”. Strategies were often initially experienced as instrumental and mechanical ways of dealing with problems, yet overtime began producing desirable change: “I can see how, what seemed almost silly, superficial approaches to human behaviour can change the structures of your approach to life”. However, in order to produce desirable effects these strategies needed to have personal relevance as opposed to being “a generic tool kit” or a “generic box of tricks”. Participants spoke about interventions that worked as engaging them on intellectual as well as deeply psychological level. They also pointed out the difference of the knowledge acquired through reading a self-help books and one developed through the process of meaningful personal interaction, or as one participant put it “[the knowledge] that was woven into that therapeutic encounter”. There was consensus amongst participants that practical suggestions needed to be developed in the context of a meaningful therapeutic relationship, which reflected insight about ways in which participants operated in their own lives.

Participants stressed the need for ongoing practice of newly acquired skills: “It is like a muscle. You have to work it and train it”. The more they were able to understand their own bodily reactions, the more perceived self-control. It is likely

that increased bodily awareness led to an expansion of self-awareness. This is supported by some authors. Pascual-Leone and Greenberg (2007), for instance, postulate that bodily felt sense lies in the core of the experiencing process, which if blocked leads to various forms of dysfunction. Disturbance in this process leads to development of distorted views, in which past perceptions are imposed on the current experiences. They argue that change is achieved by helping clients to tune into their current bodily reactions. This facilitates an integrative process between the body and mind. This is supported within the field of neuropsychology. Similarly, Schore (2003), stresses that therapeutic technique first need to assist in building awareness of the sensorimotor level of experience (bodily awareness). This then helps the client to elevate these affects into a more mature level of self-reflection and appraisal. Further to this, new findings regarding the neurobiology of psychotherapeutic experience, suggest the importance of amplifying right-brain emotional 'whatness' -the qualitative nature of experience (Gerhardt, 2004; Panksepp & Biven, 2011).

**Model specific interventions.** Typically, participants described a variety of interventions specific to the psychotherapy models. Amongst the array of techniques, the most frequently referred to were cognitive behavioural techniques including: psycho-educational interventions, restructuring schemas, and developing new, more adaptive coping strategies. These provided clearer frameworks for previously misunderstood experiences. As one participant explained, "helpful for me was somebody putting a framework around some of the interactions ...somehow, there is some level of confidence or comfort from that".

Psycho-educational interventions included information and explanations provided within the session. Participants often did not understand why they were behaving, thinking, or feeling certain way. Explanations gave them some direction as well as contextualize demystified, and normalized their behaviours. Another participant explained the benefits of providing books and other reading materials:

She gave me information and I read it and it just went ding, ding, ding, ding, ding, ding, ding. Like, my whole life went like that. Yeah, things that I couldn't understand in the past about my father, about my mother, about people that were close to me, about friends, about a colleague at work, they just all fitted the mould. So it was like ... a light went on, some real recognition,..., huge.

Schemas were restructured when therapists modelled a non-judgmental way of speaking and invited the client to change the language they used to describe their own experiences:

He wouldn't let me use certain words because they were ... very harsh and judgmental about myself, and although I still felt them, he wouldn't let me use them. I had to use softer words and stuff ... and all those little things help.

Another aspect of this intervention included reframing the client's experience: "there is a fresh painful experience, and yet she reframed it as new courage on my part which I didn't expect". This was also described as a diffusion technique: "I think she came up with words that I could use when I was noticing that I was judging". This promoted development of a new, and more inclusive schema that incorporated positive dimensions to the painful and negative experience. Participants recognized that challenging cognitive distortions facilitated development of new schemas:

By challenging, I mean a very gentle sort of questioning as to what I meant by that statement and consistently arriving at a point where I did tend to be more yes/no black/white .... and so through her questioning, getting me to that point and then allowing me to realize that of course the things we were talking about could not in fact be black and white. There had to be the full sort of spectrum of experience on these topics.

Increase in self-awareness and the development of more adaptive sets of behaviours frequently resulted from an application of cognitive behavioural techniques. Participants described sequences of exploring thoughts, feelings, and behaviours, which subsequently led to developing more adaptive forms of reacting and relating. Consequently, a lot of emphasis was placed on the significance of new coping strategies: "I think it just taught me a different way of seeing things and doing things, and taught me ways to cope that I hadn't had before, coping mechanisms that were really good". Another highly valued technique, particularly evident in the context of cognitive behavioural therapy, was the provision of structure via development of treatment plan and goals: "she asked me what are your short-term goals, your long-term goals, what do you want to change? And we worked on that each time I saw her, which was good ... to see a direction and where I was actually heading with it".

Participants also reported application of various experiential learning components. These included: in-session practices to raise body awareness; relaxation techniques; role-play; and specific exercises aiming at rehearsal of skills developed in therapy. The most commonly mentioned strategies were body awareness

techniques. Initially participants required guidance from the therapist in developing body awareness and recognizing connections between emotional and physical reactions. Once developed, this expanded awareness was used as a psychological barometer. The expansion included a physical dimension of what was previously only known cognitively. The significance of bodily awareness in accessing deeper emotional states was frequently acknowledged as very helpful. The following example provides an evocative illustration of this process:

I was talking about my sense of self-sabotage, and she was saying, 'So, where is the sabotage in your body? Where do you feel it?' Straightaway my throat just started clamping up and felt really, really tight, and as I was saying it, it was getting tighter. And she said, 'Put your hand on your neck and just breathe into your neck for a while, and it was just getting tighter and tighter and feeling worse, and the more focus I was putting on my neck the more it felt like I was strangling. And then she asked me, 'What does your neck need?' .... 'If it could talk, what would your neck say that it needed?' ... and then it was just welling up of emotions. I just felt really, really sad about how I couldn't say what I meant and that it all kind of got caught in this part of my body, energetically where self-expression was really difficult on all these different levels, and I just had lots of grief about it, about how it has just been there for so long. And I started crying but couldn't really cry because my neck felt so strangled, so I was crying in a very pent-up kind of way and not from a deeper part of me. And then she said, 'Put your hands down near your belly, and what is happening there?' So she brought the feelings down into my body and I felt more grief down there .... it was quite a profound moment. I think I was almost chit-chatting about how annoying it was that I couldn't do my guitar practice, just from her kind of bringing it back to what was actually happening in my body rather than talking. I think that is a good way to access feelings.

In this case, the client was guided by the therapist in the process of opening up and being in touch with emotions which were previously inaccessible to her. By directing attention to the bodily sensations connection with deeper and painful feelings was restored. It was via bodily channel that the client gained fuller access to her difficulties. This experience on interconnected levels of body and mind enabled new and profound realizations.

Emotional regression comprises another model specific intervention that participants found particularly helpful. Typically, this was established through in vivo exploration of the significant events from the client's past. Some participants described intense experiences of emotional regression as a means of accessing deeper levels of emotional structure. Some of the participants in describing this process used terms such as "very confrontational", "at times felt dangerous", "fear is enormous", and "quite irrational and surreal experience". The significance of reworking these early emotional states with the assistance of the therapist was

stressed in the following statement: “I had memories resurfacing and all this stuff that you read about and can think about, but for me feeling that gives you a whole different perspective on it. ... while I can think about a lot of this, but going into therapy it was almost like going back to being a child emotionally”.

Working with early traumatic experiences in an emotionally regressed state enabled some participants to process these experiences fully and subsequently distinguish between the past and its problematic re-enactment in the present. This process of gaining access to early emotional states and ways of working with their therapeutically has been summarized in the following excerpt:

I was in tears and I was very upset and he just said very gently to me, ‘just stop for a minute. I want you just to think how old are you feeling just at the moment?’ And I just went, ‘Seven.’ And I literally felt like the child. I went straight back into that child, and as soon as he said it, ‘How old are you feeling?’ and I went, ‘Seven’ my psyche,..., just went, ‘I am a seven-year-old’ and I just went and curled into effectively a protective state. So it sort of brought the real child into the process and it made for me the seven-year-old girl come right back into the present and to be very, very strong and I guess a very powerful force in my behaviour at that time.

‘Well, what happened when you were seven?’ And there was quite a traumatic experience for me then, and then it is that understanding about, ‘Okay, that is actually still playing a part. Even though I can rationalise the situation when I was seven it still affects me now.’ So that awareness that it is still affecting me now, I can then kind of go, ‘Hey, that is not the issue here; you can separate it.’ I got more self-awareness that I can separate those sorts of things.

As illustrated in this excerpt, re-experiencing of salient events in therapy lead to change. Frequently this process led participants to an exploration of their early childhood and its impact on their present life: “just going back to my childhood and seeing where I had come from and what I had been exposed to ... I think seeing that that might have impacted on how I had actually developed as an individual”.

Another participant provided an evocative illustration of the process of emotional regression and its therapeutic benefits:

He said, ‘You are walking around the park and there is a kid on a swing and as you get closer the kid is crying. You know, she is five or six and she is crying. And, you know, she has no mother around. What are you going to do?’ And I thought, ‘Pick her up and hold her and comfort her’ and then he said, ‘Go on a little bit further and it is the same scenario but the kid on the swing is you.’ Now, at the beginning of therapy my thing to him was, ‘I want to just slap the little fucker!’ you know, because that is how much I was so disconnected from me and the child that needed that,..., but now,..., we do the same thing now, and with her on the swing and of course I will pick her up and I will hold her and I will comfort her until she feels better. And that has happened over three years.

Some participants emphasized the importance of acknowledgement and validation of early difficult experiences: “talking about childhood unhappiness or



expressing a lot of frustrations I had there and having that contained was more helpful ... and that it was deemed appropriate for the situation ... having it recognized for what it was”. There were also instances where participants were confronted with very early preverbal emotional experiences. Accessing and processing these emotional states belonging to the very early stages of life proved highly therapeutic. Through establishing links between the current states of mind and emotionally laden early experiences more coherent meanings evolved (Fonagy & Target, 2002; Schore, 2011). As a result of this process, some participants developed an internal ‘parenting’ function for the early parts of self. This is consistent with findings from developmental affective neuroscience that suggests that processing early affective states in the context of relational experiencing is central to change (Schore).

Amongst less common model specific interventions was transactional analysis with its focus on child and adult levels of communication; hypnotherapy; psychoanalytic psychotherapy with its use of free associations and transference interpretations; mindfulness and other forms of body centered psychotherapy. Dream exploration, and the use of metaphors and images were listed among model specific interventions:

And there was one moment in therapy that I remember where we were doing some sort of imagery work, like around free association, and these two different parts of me, they had got sort of names and characters and personalities. And the therapist says, ‘Can you imagine these two sort of parts of you just holding hands?’ and it was like, “Oh yeah, I can’ and like as soon as they held hands they sort of supported each other. One didn’t have to do all the work and another want all the work, and it was like, ‘Oh they are just together now and that is okay.’ So, that was quite important.

This participant stressed that while she has been discussing these issues in therapy for a long time, it was actually having the visual image of these disconnected parts as coming together that facilitated internal integration.

Amongst psychodynamic interventions, working with transference was frequently mentioned. One participant provided the following illustration:

I was telling her of a friend I was really close with but in some ways he is a bit condescending and is always telling me what to do. And she said, ‘Does it feel that way sometimes?’ I said, ‘Like what?’ She said, ‘Do you feel like I’m talking down to you?’

Another factor that promoted transference was the use of a couch in psychoanalytic treatment. This model specific intervention was described by the participant as a

factor that intensified the therapy. It is argued within psychoanalytic literature that lying on the couch with the therapist being out of the direct eye line encourages transference because the visual cues typically used for the verification of our own thoughts, ideas, and reactions are not available (Grotstein, 2007). This process is well illustrated in the following statement: “Are they going to disapprove of what I’m saying?” and I would immediately scan their face and dismiss, ‘Oh no, they are fine’ but on the couch you don’t get that”. Research on the use of the couch in therapy further suggests that lying down and not making eye contact, spontaneously activates a cerebral hemispheric shift in terms of modes of information processing from the left to the right side of the brain (Lable et al., 2010). This, in turn, allows for associations produced by the client to be “free” in a sense that they are disconnected from the left-brain editing, censorship, and control (Grotstein, 2007).

### **Hindering Factors**

Inquiry about hindering aspects of therapy revealed disproportionately less material than the section on helpful aspects of therapy. When reflecting on their most recent therapy, it was not uncommon for participants to state that there was nothing unhelpful or that they did not remember anything particularly troubling. Common responses included: “I never felt angry or frustrated with the therapist. I always looked forward to going, always enjoyed it”; “I can’t remember any single event and I can’t remember ever leaving a session in which I felt dissatisfied with the encounter in any way, which is most unusual for me because I am highly critical”; and “some days you didn’t really get anything out of it, but I never had a negative experience out of all of that”. While it is surprising just how little material participants provided on unhelpful aspects of therapy, it could mean that difficulties were addressed and managed better than in previous therapeutic encounters. It could also reflect self-selection of the sample, in that clients who had an overall positive experience were more likely to be approached by their therapists and also were more likely to agree to participate in the study. In giving examples of difficult and counter-therapeutic occurrences, participants, by and large, referred to experiences from earlier therapeutic encounters, which were shorter in duration and generally described as less helpful.

Participants, on the whole, admired, respected, felt deeply connected to, and even idealized their therapists, which might have made it difficult to remember instances that were experienced as unhelpful. The psychotherapy literature suggests

that the end of therapy is often marked by either a sense of disillusionment or a move towards less idealized perceptions of the therapist and therapy (Salberg, 2010).

However, the current research findings suggest that this process is much more complex than just ‘growing out of’ idealization. Rather, the significance and function of idealization changes over the course of therapy. Therefore, the limited recall of hindering aspects of therapy might be explained as facilitating both termination and the post-termination phase. In other words, the purpose of idealization at the stage of termination is to enable the client to transition ‘out of’ therapy. This could be facilitated by the consolidation of a positive image of the therapist; hence the disproportionately higher number of idealized memories of therapy.

This form of idealization possibly functions as a transitional object - an internalized image of a positive and reliable other, that is used as a means of providing comfort, strength, and guidance after the therapy ends and the client can no longer rely on the therapist’s presence. Craige (2002), in a study on the post-termination phase, showed that after a ‘good-enough therapy’, the clients internalized not only the therapist’s functions and attitudes toward them, but also a sustaining, positive internal image of the therapist. This can shed some light on why participants in the current study commonly found negotiating termination of therapy to be a sensitive and difficult process. They were not only leaving a very significant relationship, but were also grappling with anxiety around sustaining a ‘good internal image’ of the therapist. These findings suggest that the struggle to terminate is ubiquitous to any ‘good-enough therapy’ and partly arises from the anxiety around having to sustain a ‘good enough’ internal image of the therapist, while relinquishing the physical presence of the therapist.

Termination can be also understood in terms of a transition from a ‘two-person experience’ of self to a ‘one-person experience’. This differs qualitatively from ‘the one-person’ experience in the early stages of therapy, when a strong attachment is yet to be developed. Hence, the form and type of idealization would have a different function at the end of therapy, where the therapist is internalized as a ‘good enough’ object (Hurry, 1998). Although speculating, it is possible, that at the point of a more mature transition from the ‘two-person experience’, the client may try to fulfil the need for a more realistic version of the image of the therapist. This is different to the less realistic and more infantile image, which operates during the early stages of treatment. Such speculations are consistent with some analytic theorizing, where a

focal concern of the termination phase is the struggle to internalize the therapist; by this stage the therapist has become ‘a real object’, as opposed to the early stages when they are idealized as ‘a transference object’ (Moore & Fine, 1990; Orgel, 2000). Clients, therefore, must disentangle themselves from the therapist and the transferential form of idealization. One way of conceptualizing this comes from Ogden (1997), who suggests that the client and therapist lose themselves as separate individuals in the therapeutic experience, and “it is only through termination that each retrieves a sense of being a discrete mind” (p. 28). This function of idealization and termination can offer some insight as to why overall recall of the unhelpful aspects of therapy was sparse in comparison to its helpful counterpart. In summary, the following material is predominantly from previous therapies, with the exception of the category of difficult terminations. Nevertheless, this material points to the significant differences between unsuccessful and successful therapies. The key factors that emerged from the analysis on hindering factors are summarized in the following table (*Table 11*).

Table 12. *Hindering Factors: Frequency of Occurrence of the Theme*

<b>Routinized Approach</b>	<b><i>General</i></b>
Rigid preconceptions	<i>Variant</i>
Premature goal setting	<i>Variant</i>
Mechanized process	<i>Variant</i>
<b>Hindering Techniques</b>	<b><i>General</i></b>
Inaccurate interpretations	<i>Typical</i>
Excessive or Limited structure	<i>Variant</i>
<b>Impaired therapeutic relationship</b>	<b><i>General</i></b>
Fear of being judged	<i>General</i>
Limited attunement	<i>Typical</i>
Lack of safe space	<i>Variant</i>
Difficult terminations	<i>Typical</i>

General: all cases or all but 1; Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

## Routinized Approach

Generally, participants experienced the therapist's rigid conceptualization and rigid treatment approach to their problems as very unhelpful. In these instances, participants' descriptions cantered on the therapist's assumptive and inflexible thinking. These were grouped into the following themes: rigid preconceptions, premature goal setting, and mechanized process.

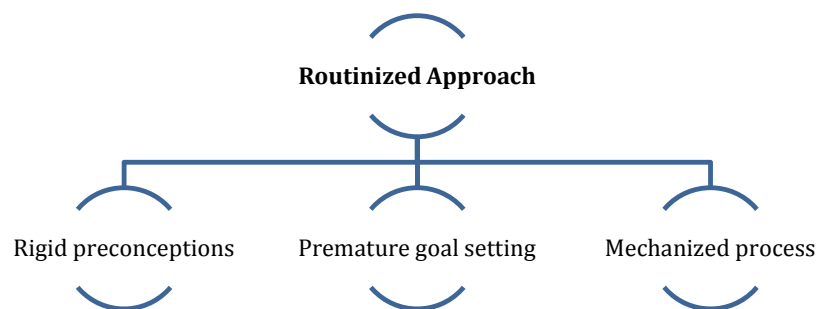


Figure 17. Routinized Approach.

**Rigid preconceptions.** Participants recognized as unhelpful, the therapist's inflexible, pre-emptive, and assumptive ways of thinking. One participant described this in the following way: "It was their approach I didn't like. I found that everyone had the same, 'Oh, it is all your parent's fault.' .... I just didn't find it useful". A different example of a rigid approach is this excerpt:

I had been seeing someone there who was very CBT. She is very lovely, had her boundaries and all, very, very clinical, very sterile, and in a lot of ways unhelpful, but she was free. So I kept going. She said that she didn't think she was the person to help me. She was just so out of her depth. This poor woman, freaking out.

This excerpt may indicate that therapist's insufficient understanding of the client's issues, leading to an inflexible use of therapeutic technique. The therapist is portrayed here as clinging to the explicit use of theory and technique. In cases like this, theory and technique appears to be prioritized and imposed over the client's experience, instead of implicitly accompanying it.

Another participant provided a description of being assessed and responded to from rigid theoretical preconceptions:

I went to see him. Basically, we had this one session and he took all the history and I came back and he said, 'You should have antidepressants.' And I went, 'Well, I don't want them.' And he said, 'Well, if you don't want antidepressants, there is really nothing we can do for you. So, I would suggest' ... that you should go home

and continue to pretend that you are happy because that is a very good coping mechanism.’ And I went, ‘Fuck!’ and he gave me some pamphlets to this women’s place that goes into women’s stuff. And I think I went, ‘I don’t think I even want to do psychology.’ That didn’t match what I would have expected from somebody in terms of being listening and being respecting and caring and those sorts of things.

This is an evocative illustration of how conflict between client and therapist theory of change led to a severe alliance rupture and premature treatment termination. Duncan et al. (2010) made a similar argument in their review of empirical studies about the client-therapist theory of change. They proposed that the lack of congruence between clients’ beliefs about the causes of their problems and the treatment approach results in ruptures, decreased duration in treatment, and lower rates of success (Duncan et al., 2010). In addition to this, some studies suggest that it is not the prescribed technique that carries detrimental effects, but, instead, it is its rigid application that interferes with positive change (Hayes, Castonguay, & Goldfried, 1996). Interestingly Hayes and colleagues also found that technique variables affected relationship variables; that is, therapists’ adherence to prescribed and rigid interventions increased when confronted with ruptures in the alliance, wherein the stronger the client’s resistance to the proposed technique, the greater the therapist’s insistence on it. Such defensive adherence exacerbated the rupture in the alliance, ultimately leading to poorer outcome (Hayes et al., 1996). This process is reflected in the abovementioned excerpt, where an intervention dictated by inflexible etiological explanations appeared to impair the therapist’s attunement. In this case, the negative reaction was brought on, not only by the client’s disagreement with the proposed form of treatment, but also by the impersonal and instrumental nature of the therapeutic encounter. It seems that it was the preclusion of the client’s perspective that deepened the client’s sense of helplessness and ultimately diminished trust in the profession of psychology.

**Premature goal setting.** Participants opposed being offered immediate ways of addressing their difficulties. They felt objectified and either misunderstood or understood only in very superficial ways such as: “the [therapist] rushing to make sense of my experiences or kind of intellectualizing things too quickly, saying things that I already really know about myself”. One participant expressed her disappointment at the therapist’s impersonal and prescriptive approach to her problems. She stressed the need for time to process what had happened to her, rather than premature treatment planning and goals:

She was very much, ‘Now, we should have a goal.’ This is the way it went. ‘We have a goal and have a little plan to get there’ and I’m just looking at this woman thinking, ‘My whole world has just been ripped out from under me. I don’t know what is true, what is not true. I can’t pick one thing. I don’t know what I need to keep here.’ Had she not been quite so structured ... I find that really hard, contracting, on that level. I think it is sometimes unnatural.

Participants frequently discussed the problem of having been responded to in a “*rushed*” way which conveyed the message that one was not worth being fully understood, with all of one’s complexities and idiosyncrasies:

I had one session with one and decided against it because she had a ‘let’s fix it’ approach. I felt rushed and I felt silly, for even being immature enough to have distorted thinking patterns. Just the whole way it was set up was, ‘we’ll correct your distortions’ and ‘just fill out these worksheets’. It was very kind of prescriptive. I felt as though she wasn’t really listening to me or really even seeing my problems as worthwhile.

This tendency may be associated with time constraints under which therapists often have to practice. This was reflected in research findings showing that negative client outcome was associated with a lower number of sessions and higher therapist caseload (Borkovec, Echemendia, Ragusea & Ruiz, 2001). This sense of being ‘rushed’ was also referred to as an “assembly line feeling” where individuality, uniqueness, and sense of self-discovery have been lost. In the case of another participant, this created concern about being defined through the lens of the problem:

If a therapist jumps in too soon and says, ‘We can solve this issue’ I think sometimes you get quite attached to your issues and they feel like part of your identity, so maybe more of a sense of ‘Let’s explore and get to know who you are and how you work.

This notion is reflected in research findings showing that when the client felt unprepared for interventions this was hindering (Castonguay, 2011).

The distinction between ‘ego dystonic’ and ‘ego syntonic’ problems proposed by McWilliams (2011) sheds some light on the issues raised by these participants. She states that if the problem is perceived as ego-dystonic (alien) to the personality, the client often finds it uncomfortable and expresses a desire to overcome it. If, on the other hand, the problem or symptom is ego-syntonic, it is experienced as part of the personality and therefore is perceived as not requiring change (McWilliams, 2011). When the problem is ego-syntonic, interventions directly focusing on symptom-reduction might be experienced as pre-emptive and therefore resisted. Similarly, premature ways of assessing difficulties and offering

quick ways to solve them prevented the client from having, what one participant described as, “the awakening in my own time ... space to have all of that happen organically in my own time “. Another issue arising from premature problem conceptualization was described in the following way: “ironically, it is also feeling as though your problems can be solved”. This obstructed recognizing and having a ‘felt’ experience of ‘injured’ aspects of self: “there is something in me that wants to feel damaged sometimes and wants to have space to feel”. This further signifies the importance of allowing the psychological situation to evolve without premature concretizing of the presenting problem.

**Mechanized process.** An instrumental and technical approach to therapy was recognized as unhelpful. Some of the expressions given to this experience included “other things that kind of get in the way ... handing out the worksheets accordingly, and you just feeling patronized in that way”; “you are just at a particular step in the program and people have been there before you and you pop out the other end .... maybe the ego gets a bit offended by that”; and “I felt like I was being dealt with a practitioner with a bag of tricks. I didn’t have respect for their knowledge or their skills in that encounter”. This type of exchange between the therapist and the client is further illustrated in the following example: “The end points, the linear step by step, doesn’t appeal to me. And actually, all of the things that aren’t useful for me that I mentioned kind of fit into that structure of therapy [of fixing things]”. These findings are consistent with an early study conducted by Strupp and Hadley (1977), in which practitioners of cognitive and psychodynamic orientations have ascribed negative reward to the therapist’s rigid and mechanical application of technique. More recently a study that (Castonguay, Boswell, Constantino, Goldfried, & Hill; 2010) explored unhelpful aspects of each psychotherapy session also indicated that clients found rigid and mechanical adherence to therapeutic technique unhelpful.

Short-term and structured therapy was experienced by some participants as mechanical in nature: “when you are looking at some of the straight six-week CBT for this, to me that is a very band aid therapy. ‘These are the symptoms; let’s cover them over’, as opposed to going, ‘Why were they there in the first place?’” A mechanized process was frequently experienced as depersonalizing, as its sole aim was to ‘teach’ new ways of thinking: “What I didn’t like was when they would, one, had a white board. I think they were trying to tell you the levels of communication, but they would sit and write all that up there”.



The main association in this case was a “schoolroom”, which exacerbated a sense of inequality. This instrumental way of responding is further explained by the following participant:

I wouldn't value therapy that I walked into and the therapist just sort of put me through a process and said, 'Okay, we are going to do this because we are at this stage and we are going to do that because we are on that stage.' Well, it might work for some people, but it wouldn't work for me. And that is, I guess, where the previous therapy only lasted a short amount of time, which was something completely different. It was just useless. I just gave up. I just felt like it was just putting me through a process. And they were both psychologists.

Separating a mechanized process from a more individualized experience of therapy was well expressed through the metaphor of musical composition:

So with therapy 1, if I had a recorder going on, I would have just released that as the album. With therapy 2 there were a lot of raw materials. I would go home, I would produce it, I would cut and paste, I would do whatever I need to fix it up. I would add some effects or add some rhythm or do whatever it needs to touch it up to make it more polished on my own.

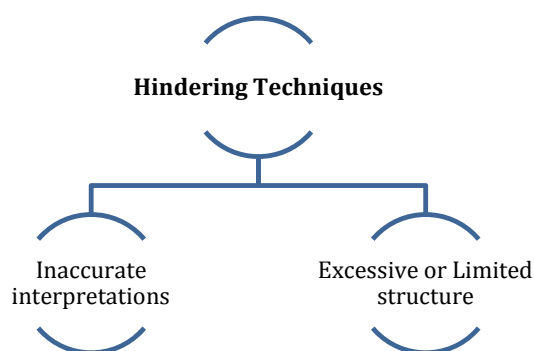
In this case, ‘therapy 1’ was compared to the perfect musical composition which did not require subsequent work for it to be a true representation of the client’s internal experiences. In this therapeutic encounter the therapist did not have to rely strongly on her theoretical formulations and was ‘free’ to relate to the client. This made the experience personified and therefore meaningful. This was contrasted with the ‘therapy 2’, which felt different to this participant, in that, it required a lot of subsequent work to make it into an accurate reflection of his internal experience. In this instance, the therapist was mechanically applying theory leaving the client with the ‘raw material’, which he subsequently had to process into something personally meaningful. He further explicated that ‘therapist 2’ “had her theories in mind. I could see it working .... It was like she was so preoccupied with giving me a formulation and a reflection that it occupied a lot of the talk time”. However, if interpreted from the perspective of learning theory, ‘therapy 2’ could be seen as equally helpful. In this instance, insight and lasting change could have resulted from some level of initial mismatch between therapist and client understandings. This misalignment promoted the client’s active engagement, re-evaluation, and re-organization of existing ways of thinking, feeling and behaving.

This further points to the use of theory and its effects on the development of the therapists’ states of mind. For example, Chianesi (2007) emphasizes the role of theory: “the ‘facts’ do not speak unless someone has organized them into a structure

that allows them to speak” (p. 27). Ornstein and Ornstein (2003) form a similar view in saying that we cannot avoid the use of theory in the treatment process, as without it we would not be able to make sense of what the client is presenting with. However, there is another aspect to this process, namely, the therapist’s state of mind, which needs to be sufficiently open to the client’s communication in order to participate in the process of mutual construction of meaning. This is necessary to prevent what Levine (2012) described, as simply decoding and uncovering meanings through the application of particular theory. In order for this to occur, the therapist needs to keep his internal psychic space open, i.e., needs to make enough room within him or herself for a deeper engagement with the client. Rigid adherence to theory, or as expressed in the above example, ‘thinking through theory’, prevents this mindset from developing in the therapist and consequently in the client (Levine, 2012).

### **Hindering Techniques**

The analysed material revealed various ways of implementing interventions that were obstructive to a positive outcome. Hindering techniques included inaccurate interpretations and an excessive or limited structure of therapy.



*Figure 18.* Hindering Techniques.

**Inaccurate interpretations.** Typically, participants recognized inaccurate interpretations and suggestions as hindering to the therapeutic work. Such interpretations and interventions would commonly result in the experience of being misunderstood. Participants, however, emphasized that there were times when even the most attuned therapists made inaccurate interpretations or suggestions: “I do also remember times when she might have said something and it was like, ‘I’m not sure

about that”; and “the time she was way off the mark, and she actually said that to me. She said, ‘I’m not sure if this is my stuff, but is it about this?’ and I said, ‘No, that’s not me. That’s you’”. One of the states that produced inaccurate interpretations was when the therapist was thinking in isolation from the client’s own process of self-discovery:

I had made a decision about some work that I was offered and I was going to accept it and ... she had another perspective that it might not be good for me to accept the work, and for me that was ... a bit like the interfering mother .... I did later decline the work, but for different reasons than she was suggesting, but it was about me coming to my own conclusion for the right reason for me .... I think normally she was very good at that. Just in that particular instance, that wasn’t helpful for me having that suggestion from outside of my process.

Sometimes, inaccurate judgment on the part of the therapist as to what issues needed to be explored became hindering to the therapeutic process:

I got angry then, because I said, ‘You are pushing me on something when there is nothing. There is nothing there for me. I don’t have any emotions on it, and I know my emotions.’ It was just like, ‘there is nothing there. You know, just don’t push me on it. There is nothing on it.’

In this case the therapist offered a specific interpretation and directed the client towards deeper exploration of the matter. As can be seen from this excerpt, the client reacted strongly to suggestions that did not fit her experience. Alternatively, the therapist’s interpretations may have been premature and were directing the client towards an experience for which she was unprepared (Casonguay et al., 2010). This is consistent with Freud’s (1913/1993) early contention that premature interpretations are errors that can jeopardize change. He advocated refraining from the use of interpretations until a strong therapeutic alliance had been established, because they are likely to trigger strong resistance in the client, especially if they are correct: “Usually the therapeutic effect at the moment is nothing; the resulting horror of analysis, however, is ineradicable” (p. 187). Freud’s argument provides support for more recent research findings, indicating that premature and higher level interpretations are associated with poor treatment outcomes (Crits-Christoph et al. 2011). Freud’s further warning was that the therapists’ should sparsely dispense interpretations, even after a strong rapport has been established, and to offer them only when the client is about to discover for him or herself the meaning behind a symptom or desire. This notion is further reflected in Greenberg, Rice, and Elliott’s (1993) research findings that the use of interpretations in experiential therapy can have a detrimental effect, as it set the therapist up as an expert on the client’s

experiencing, causing the client to feel disempowered. Both place emphasis on the non-directive and non-pre-emptive nature of the therapeutic process, in which the client needs to experience him or herself as an agent of change.

**Excessive or limited of structure.** Typically, therapy with either a limited or an excessive structure caused participants some anxiety. While the majority of participants acknowledged lack of structure as disconcerting, only a few talked about their struggle with an excessive structure of therapy. Excessive structure was associated with the therapist's exertion of too much control over the process of therapy: "obviously firm boundaries are important, but I think there is some delicacy around being firm and not being controlling". The imposition of too much structure was often expressed through the excessive reliance of psych-educational content:

I don't want my therapist to be a teacher really...., it is all very subtle, isn't it? I guess everyone is a teacher to each other, but I guess when someone puts themselves in that role as an educator you sort of sense that they are positioning themselves.

Another expression of excessive structure lay in adherence to a rigid therapeutic frame. Despite understanding the benefits of a strong therapeutic frame, this participant at times recognized her own struggles with feeling restricted by the excessive structure: "there was a part of me that wanted to kick against the structure of the therapy ... the analytic frame .... Why is my therapist so strict?". In these and other cases, the therapists' inflexibility and rigid adhesion to structure might have been a compensatory measure for a lack capacity to respond to and manage therapeutic situations. This is also related to the therapist's rigid preconceptions in which theory and technique seems to be explicitly imposed instead of implicitly accompanying the client's experience.

Far more frequent, however, were complaints regarding the therapist's lack of structure and direction:

I felt a little lost in the directions I was travelling, in the way I was discussing and covering issues. I would have preferred some more guidance from the therapist on which topics to consider pursuing and also maybe keeping me ... on a particular topic to allow further opportunities for growth and insight and understanding in that area. I felt, at times, I was wandering a bit; and I see it as a therapist's role to keep the client engaged in whatever was the chosen direction for that day. And I also regret that the therapist didn't hold on to topics from previous sessions and raise them, as areas that we could continue discussion in. So it was for me ... a ... free-flowing way to address topics which maybe could have been addressed more sequentially.

One participant contrasted two therapies, one that she found very helpful and the other one as being of no assistance:

In the beginning she asked me to write down all my goals, so I had direction, whereas the first person I went to there was no, 'What are you actually working towards?' It was like, 'Well, what is your problem?' on the day, whereas [the second therapist] it was, 'Okay, your short-term goals, your long-term goals, what do you want to change? What do you want to talk about? Where is it all coming from?' And we worked on that each time I saw her, which was good.

Similarly, Castonguay and colleagues (2010) found that clients experienced therapists' failure in providing them with sufficient structure or support as hindering.

Some participants expressed ambivalence in relation to non-directiveness and lack of structure. On the one hand, they wanted their therapists' to review discussed material, help them reflect on the changes that were made, and provide some future direction. On the other hand, this lack of direction facilitated greater presence 'in the moment' and gave rise to very insightful and powerful personal discoveries:

He would never tie it all up neatly at the end or sort of say, 'Let's go over what we have covered' or even mention what happened the week before. It was always just moment by moment by moment and that used to give me a feeling of being lost, sort of like, 'Wow, what was that?' kind of feeling as though there was no progress perhaps, but, yeah, actually looking back I really appreciated it. There were lots of powerful moments in just letting go of future and past and the concepts in my head.

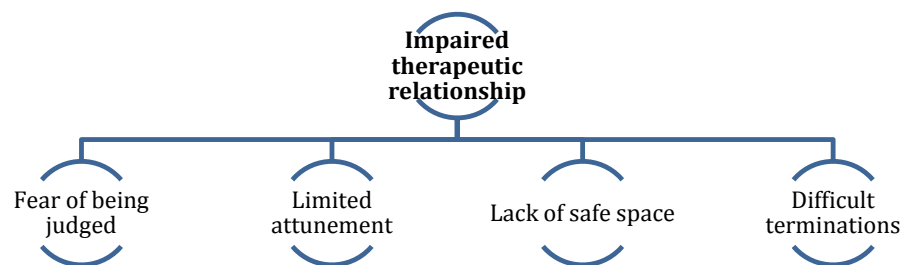
What seemed to be recognized as valuable, was the ability to maintain the internal act of waiting where future and past pre-conceptions were suspended and some new illuminations and insights developed.

In some instances, the lack of note taking during the session contributed to a sense of limited structure. This was experienced by some participants as "highly unprofessional" behaviour that provoked their anxiety, as they feared the therapist would lose continuity of the process and a sense of direction: "the first one was a two-year process of - - I didn't see any of the notes. There was no homework as such, but it was just very much a, 'So, how are you feeling today?' and I found that to be a waste of time. I wasn't getting anywhere". In contrast to this, another participant recognized as unhelpful the fact that the therapist was noting down "unimportant information". In response to the client's question: "Is that important?" this therapist replied: "Oh no, no, no, it is just for me to remember". These excerpts highlight the importance of greater transparency with clients about the process of note-taking. It seems that clients often make inaccurate assumptions regarding record

keeping, particularly as it is a very common practice for therapists to take process notes after the session is finished.

### **Impaired Therapeutic Relationship**

Characteristic of impaired therapeutic relationship were the feeling of being negatively evaluated by the therapist, a lack of safe space, the therapist's limited attunement, and difficulties surrounding termination of therapy. Other therapist-related behaviours frequently reported as detrimental were misattuned therapists, fear of being judged by the therapist, and a lack safety in the therapeutic space.



*Figure 19.* Impaired Therapeutic Relationship.

**Fear of being judged.** Generally, participants discussed their fear of being negatively evaluated and judged by the therapist as obstructing the therapeutic process. Some of them reported having negative experiences in their previous therapeutic encounters, which conditioned them to fear the same in the subsequent therapy: “the first man I went to, you could see he was kind of judging you when you would say things”. Judgment was strongly feared in the early stages of therapy before trust was solidified:

I think that developed later, because initially there was this sense of me versus her. I think that was just me, that, ‘Oh, if I say something, is she going to think that about me?’ or ... ‘What is she going to think if I say this?’

This, for some participants even extended to fear of being judged for being in therapy: “what will people think ... if they know that I have been doing therapy for seven years? I am doing twice a week”. Time, in some cases, did not eliminate difficulties in expressing some truths about oneself:

There are just parts of myself I am very, very unwilling to talk about with other people ... that was still the case in therapy. We were talking about how I had

handled a situation and so I omitted a lot of my behaviour and the significance of the situation to avoid having to talk about why I had behaved in that manner.

Others also acknowledged that fear of being judged made talking about shameful things very difficult: “because of the amount of shame involved around these topics there was a strong sort of emotional side to it and I am disinclined to talk about this. But I would think long and hard about whether or not I would omit something from therapy”. Similarly, participants in the study conducted by Farber, Berano, and Capobianco (2004) found disclosure of shameful material initially anxiety generating, but ultimately leading to a sense of relief. This is consistent with other studies which show that post-disclosure feelings are largely positive, indicating that shame is largely anticipatory (Hall & Farber, 2001; Rennie, 1994). Farber and colleagues further proposed that shame associated with disclosing intimate or previously secret material needs to be understood within a powerful and complex interpersonal context. That is, just like in current study, their participants were concerned with therapists’ thoughts, feelings, and behaviours, before, during, and after disclosure, further showing that the decision to disclose shameful material is partially influenced by the quality of the therapeutic relationship.

Previous research indicated that while clients commonly anticipate shame while disclosing to their therapists, they also acknowledge that the anticipation of their therapists’ understanding and non-judgemental attitude mitigates the inhibitory effects of shame (Hall & Farber, 2001; Hill et al., 1993; Horvath & Bedi, 2002). Therefore, shame can be experienced both, as an intra and interpersonal process. The need to reduce distress is weighed against the anticipation of shame and vulnerability in the presence of the therapist, as well as psychological danger of constructing a negative self-image. According to Kelly’s self-presentation model, shame and vulnerability are powerful and salient emotions, which when connected to perceive judgement on the part of the therapist can activate protective mechanisms of censorship (Kelly, 2000; Kelly & McKillop, 1996). In conclusion, current findings are consistent with this model, in that, early in the process, clients’ decisions to reveal secrets do seem to be mediated by a fear of their therapists’ judgement.

**Limited attunement.** Misattunement was described as a ‘felt’ experience, often of the ineffable nature: “I ... felt unsupported by her and I don’t know whether she was preoccupied emotionally with something else, but I actually left feeling unsupported”; and “sometimes it felt like she didn’t quite seem to be hearing that I

was telling her”. One participant referred to this lack of emotional connection as the “therapist’s emotional clunkiness”. The misattuned therapist was also described as being on a “different wavelength”, or “trying too hard .... but a little bit too much. It didn’t come so naturally”; or even someone who “totally missed it; not just missed it, she went on a different path, for her own agenda”. For some participants, it was the tone of voice that indicated misattunement: “just a shift of tone where she was reflecting something back to me and the tone showed that she missed slightly or missed by a larger distance what I had been trying to communicate”. This participant further explained the impact this has had on the therapeutic relationship:

... it damaged the bond in some ways, because it would show that I was being misunderstood or suggested to me that my therapist had opinions about my life that were not my own. I found [this] would then lead me to feel more distance from her, which I felt would make the session drag or would make it harder to continue ... with talking intimately in some ways about my life. There would be that fairly natural impulse, the feeling that she wasn’t quite there with me meant that I pulled back slightly. Because I think it was only small things, but it would then leave possibly half a session or something before that feeling on my behalf shifted.

These excerpts indicate how subtle the signs of misattunement often were and how sensitive clients’ were in ‘sensing’ these elusive affective experiences. In contemporary literature this experience of ‘knowing’ has been variously described as affect attunement (Stern, 2002), emotional resonance (Coburn, 2001), the pre-reflective unconscious (Stolorow & Atwood, 1992), or implicit emotional knowing (BCPSG, 2010).

Misattunement was also associated with communication breakdown:

Probably the least helpful were the moments where she talked when I had things I wanted to say. Generally, she was really quite attuned to that, but sometimes she wasn’t, and I wouldn’t be hearing what she was saying anyway, because I had my own things that I was processing.

Another instance in which lack of sufficient attunement lead to breakdown in communication and provided an unhelpful experience for the client is described in the following excerpt:

I put an expectation on myself that I needed to have a dramatic insight each time. I feel this desire to perform or to make it emotional or whatever’ and I needed to ... assess that. So that was something that perhaps for me was a little bit unhelpful, because I needed to actually do that myself, and whether or not I said to my therapist, ‘I feel like I need to perform. I need to give you something’.

Here, unrecognized by the therapist, was the client’s pressure to ‘perform’ and to ‘be a good client’. Breakdown in communication was also queried by the participant



whose therapist was frequently silent: “I think my therapist was probably maybe more silent than other therapists might have been, so I’m not sure whether, if sometimes she had have said more or broken the silence sooner, that would have helped or not”.

Misattunement was also expressed in insensitive and intrusive interventions. An example of the therapist’s lack of sensitivity in attending to very personal issues is illustrated below:

He commented, ‘Oh, I like the jacket .... and then he proceeded with some other comments that for me were extremely hostile and unhelpful .... When I spoke with him about it, I said, ‘It was like the favourable comment was an anaesthetic for what was to follow.’ ... I still think that what he did therapeutically was awfully ill-thought and clumsy.

Later adding:

He had on his computer a picture of his dog and he showed me this picture .... I actually felt quite awkward. He wanted to give and share a connection, and I can go with the intent, although the experience of it probably wasn’t brilliant from my point of view. I did query him about it on a subsequent session about whether that was something that he thought would happen and he said, ‘No, it grew out of the session’.

These excerpts illustrate how slight remarks of a personal nature provoked significant discomfort and confusion for the client. In this, and other cases, limited attunement often led to an increase in the client’s distress: “I did therapy before for those few months- it was with a self-psychologist and I think I felt like my distress was increasing”. While it is likely that distress may increase during therapy as the focus is on things that have been previously defended against (McWilliams, 2011), in this case it was experienced as unhelpful. Perhaps the fact that the distress, was not well attenuated within the therapeutic encounter. It is unlikely that this participant avoided distress as she later engaged in a long-term therapy in which significant personal issues were resolved; this process inevitably at times lead to increased distress, but perhaps it was better attenuated in the latter therapeutic relationship.

Amongst more extreme forms of misattunement, were insensitive and uncaring responses, for instance: “therapist I went to just said, ‘Well, that was it, get on with it’, ‘it is what it is and get on with it’. Ultimately he is right, but he is not teaching me how to get on with it”. Another participant said: “the therapist was counter-defensive in a way that was extremely unhelpful and that had a very strong controlling flavour”. In these instances, the therapists did not seem to understand

what might promote change in their clients. The sought after help however, goes beyond 'advise giving'. A necessary ingredient, that seems to be missing here, is a relational attunement that provides the stage for change. The latter example is of a therapist inattentive to certain issues who did not work adequately enough with confronting material and was further described as: "ignorant" of how psychologically inaccessible the client was: "I was really, really, really struggling to stay psychologically present enough to be able to use the therapy". Here, lack of attunement generated and maintained feelings of isolation and lack of safety. Successful and continuous attunement to the affective states of a client can greatly contribute to the client's sense of a client of safety and, conversely, threaten that sense if the affective dialogue between therapist and client is derailed.

Research conducted by Wampold (2006) provides evidence that psychotherapist effects are more predictive of outcome than the intervention effects. His findings suggest that some psychotherapists are better at facilitating change than others. Some studies have indicated that therapists with more anxious attachment styles, characterized by low self-esteem and high emotional reactivity, establish less empathic relationships with their clients (Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006). Henry, Strupp, Butler, Schacht, and Binder (1993), reported that therapists who were hostile towards themselves, even when extensively trained on how to manage negative interpersonal processes, had higher levels of hostile behaviour towards their clients. Other studies have expanded on these findings by demonstrating that therapists' with high recall of negative childhood memories had a higher number of negative in-session interactions, which in turn produced negative treatment outcomes (Hilliard, Henry, & Strupp, 2000). The current study adds to the existing research, by elucidating some tendencies of therapists likely to have a detrimental effect on their clients. These included uncaring, defensive, and controlling attitudes, and insensitive and intrusive interventions. These misattuned behaviours, at times, directly influenced deterioration, whilst at other times impeded progress that might otherwise take place.

**Lack of safe space.** Some participants experienced their therapy as lacking in psychological safety: "I would never reveal my true self. I just didn't connect with them, so I couldn't be myself. It was almost like talking to them and saying, 'Well, this is what you want to hear'. One facet of this experience was unclear boundaries: "I started doing some therapy with a woman who was actually my supervisor for

registration, so things got blurry”. Changes to the boundaries were typically experienced as compromising psychological safety. Lack of safety also manifested in a more explicit physical form:

He would often eat his lunch through the session because he had just been for a run or something, and I just didn’t feel like he gave a rat’s ... that he cared at all, and that is really important. That is another part of that space.

One participant described how her previous therapist would often cancel their sessions: while she recognized with some astonishment that she accepted this practice, she reported that it led to feeling unsafe in the therapeutic space. There was a degree of instability and unpredictability to the physical dimension of therapy, in that the client was often uncertain if and when the next session would take place. The compromise of safety on the structural level was often translated into the psychological one. For another participant, her sense of psychological safety was challenged when the therapist was late and therefore was experienced as unavailable:

I remember her being late because the clocks changed and she got it wrong, and I remember her not apologizing and I remember thinking ‘Oh, she is putting me in my place now. She doesn’t need to apologize to me’ but that wasn’t consistent with the rest of who she was. That was my fear, my assumption.

In this instance, the client restored sense of safety by evaluating the situation and acknowledging that this kind of behaviour, despite being problematic, was nevertheless unusual for the therapist. The sense of psychological safety was also associated with the therapist’s inability to maintain mental continuity of the sessions:

Sometimes we would schedule appointments ahead and sometimes she wouldn’t have them still recorded in her diary. So if we were meeting fortnightly, then the next time she would ask me what I wanted to do in terms of a plan. So she would be repetitive and I thought we had made arrangements and she was sort of remaking them. I don’t think it interfered with her availability. It was just a bit annoying after it happened quite a few times. And that was over a lot of years, so it probably didn’t really happen that often.

In this case, the therapist lacked capacity to ‘hold in mind’ the client between the sessions. Each time the therapist forgot the future arrangement, she unwittingly provided the client with an experience of a psychological discontinuity. Previous research has indicated that one of the prerequisites for developing and integrating the self is the experience of being thought about by another person (Fonagy, Gyorgy, Jurist, & Target, 2002; Levy & Truman, 2002; Slade, 2000). Interestingly, a study conducted by Schroder, Wiseman, and Orlinsky (2008) showed that the therapist’s propensity for ‘holding clients in mind’ between sessions varies based on their

theoretical orientation; analytically and psychodynamically oriented therapists tended to recall a client's feelings and had reflected on their own feelings towards a client, whereas behaviourally and cognitively oriented therapists focused on how best to help a client address their difficulties. In some cases, safety was so severely compromised before the first session that it prevented the therapy even beginning:

Once I had an appointment to go to this therapist and I waited a month. I was really in a bad way and he just cancelled, just cancelled. And that totally, totally devastated me. I just never went back ever again to that, because you need to feel safe with your therapist and know that he is going to be there.

These excerpts show just how critical the sense of continuity, stability, and reliability is to the process of therapy, and how, when compromised, it can prevent the therapeutic encounter.

The issues of power and control were amongst the more severe safety compromisers. For example, being in "the one-down position" resulted in feeling unsafe. When unacknowledged, this sometimes extended to a power struggle between the therapist and client making the experience very unsafe psychologically: "I think he went into a counter-defence too, and I commented on that....I felt it was a power tussle and it felt very wrong for me and it wouldn't be the way that I would conduct therapy". Another aspect of compromising the safety of the psychological space was when "the therapist made personal disclosures about experiences, when I felt that they didn't actually relate to what I was talking about". In some instances, an insufficient level of 'realness' was described as one of the constituents of unsafe experience: "there was a step towards realness but not enough for me to feel that it was okay to continue the therapy".

This material strongly accentuates the importance of safety to the therapeutic process. Participants showed great sensitivity to signs that might compromise this experience. They were sensitive to anxieties deriving from any source that was perceived as safety- compromising, which often extended beyond perception alone, into 'felt experiences' on the physical, mental, and emotional levels. The lack of safe space referred to both the physical (i.e., cancelling or changing time of appointments), and mental/emotional domains (i.e., forgetting important information about the client) in the client-therapist relationship. This resonates with Sandler's (as cited in Fonagy, 2001) understanding of safety as a 'feeling state' and a 'background feeling'. He viewed the pursuit of safety as an overarching principle of psychological

wellbeing. In this sense, Sandler's notion of the 'background of safety' can be complemented by Winnicott's (1986) notion of a 'holding environment', which involves the provision of 'place' as a physical and psychological state, in which the client may safely experience himself. Both these concepts very much correspond with participants' emphasis on the affective state associated with feelings of safety and promotion of emotional growth. Participants in this study acknowledged the importance of both, a psychological and physical holding, the safety of an emotionally receptive and available therapist, as well as a predictable and constant physical space. In summary, the current findings indicate that perceived lack of safety in the therapeutic relationship can significantly inhibit therapeutic work, particularly when deeper psychological levels are concerned. The participants stressed that perceived lack of safety fostered a climate un conducive to emotional growth.

**Difficult terminations.** Typically, participants perceived the issues arising from premature, incomplete, and insufficiently processed terminations as hindering to the overall experience of therapy. In some instances, there were precipitately rushed endings, with the consequence of the therapist's relocation to another city or country:

The end ... it was my decision to end. My therapist was going away overseas, but from her perspective we could have continued using information technology like Skype and face-to-face videoconferencing, but it was my decision to end at that point. It was still pretty intense even towards the end because we had gotten to know each other so well, so that in itself was difficult ... the ending.

In one case, a premature ending coincided with other personal losses, making it particularly difficult for the client to manage:

And then towards the end of my sessions, I actually did wonder, before I found out that she was leaving, whether maybe there wasn't anything else to be really working on until I had this experience of my grandmother becoming really ill and then passing away, and I really missed my sessions with her, but by that point she had left.

Premature and unilateral endings also triggered off powerful feelings of abandonment and lack of control: "I was unhappy that it had to end when it did, which was quite interesting because I was getting to the point before she told me she was leaving that I felt like I wanted a break, but of course I wanted it to be my choice". If interpreted from a developmental perspective, the client's reaction to the forced termination could be understood in terms of abandonment, before achieving separation and individuation. As emphasized by Delgado and Strawn (2012), when

working with adolescents, successful termination includes working through and resolving early ties to the parents and achieving separation and individuation. This is echoed by Kernberg (1979) and other theorists (Burgner, 1988; Sandler, Kennedy, & Tyson, 1980), who view termination as a form of successful separation achieved, after resumption of normal development and psychological progression to the appropriate developmental level. It is suggested here, that the client's protest reaction arose at a time of psychological re-working of earlier developmental stages of separation and individuation from parental figures. Other ways of understanding strong reaction, to termination are high levels of separation anxiety (Zuckerman & Mitchell, 2008), insecure attachment styles (Holmes, 2011), or weaker therapeutic alliances (Schlesinger, 2005). Irrespective of theoretical explanations, it is safe to assume that the degree to which clients feel their treatment needs were addressed would determine their readiness for termination of therapy. Participants indicated their need for greater openness on the part of the therapist to initiate conversations around termination. Difficulties typically arose from a lack of open communication around clients' questions about the ending:

I think what is more ambiguous is the conversation about when the therapy ends or if therapy ends and how that is negotiated, and I think it is a delicate matter. So that was the only awkwardness ... in sort of talking about how that might happen, although in the event it wasn't actually an awkward conversation... I think I sort of said, 'Well, I feel like I don't need to come as often' and she said, 'No, I feel like you don't need to come as often.' But... that is intrinsically a difficult one I think.

Unlike time-limited forms of therapy, longer-term therapy does not have a set termination date. This leaves the therapist with the complex task of assessing the client's readiness for termination. The literature concerned with longer-term, open-ended forms of therapy provides elaborate guidelines on how to proceed through this stage of therapy suggesting it should be achieved via mutual negotiation (Gabbard, 2009). Similarly, guidelines for more structured cognitive therapy emphasize the importance of the therapist's open discussion and preparation of the client for termination (Beck, 1995; Weissman, Markowitz, Klerman, 2000). However, there is a very limited data on how frequently and with what effect therapists adhere to these recommendations. Knox and colleagues (2011) investigated positive and negative termination experiences; the clients that reported positive terminations described the process as planned and very positive, in which feelings regarding termination were openly shared leaving them open to future therapy; conversely negative experiences

of termination were characterized by lack of discussion of termination-related emotions and review of treatment goals and gains. These findings echo research conducted by Quintana and Holahan (1992) and Roe, Dekel, Harel, and Fenning (2006). However, the current findings strongly indicating that termination of longer-term therapy received insufficient level of attention from the therapists.

Some participants reported experiencing the end of therapy as confusing and largely unacknowledged:

So it came to the stage where you are kind of like, 'Do I keep going? Where is the end of this? Is he going to instigate the end or do I instigate the end, or what happens?' So that was probably where it got a bit confusing to me, 'Where do the boundaries lie? Who is finishing this? Am I finishing it or does he finish it? I don't want to be rude and finish it myself.'

Despite feeling confused, participants frequently identified certain signs of approaching ending: "towards the end ... I was looking for things to talk about, and that was uncomfortable"; and "I got to the stage where I felt, 'I think she should now be having a conversation with me about the next stage' you know". This sometimes led clients to fabricate issues for the therapist, in the service of unnecessarily prolonged treatment. Rushed endings were marked by feelings of ambivalence and often regretted: "I think I should have stayed in a little bit longer". One participant said that although she felt appreciative that the therapist initiated talk about termination, there was an insufficient processing of these issues:

I suspect I finished a little bit earlier than I ought to have, and in a sense it was almost my ego that when he asked, 'Do you think this is a good time to stop?' I don't say a lot earlier and I don't say he did the wrong thing asking, but I think I would have liked to have kept going a bit longer. But then I sort of thought, 'Mm, yeah, fair enough, he is probably sick of listening to me', which I'm sure would not have been the case. Well, he might have been but that is what he chose to do with his life. I suspect I did finish maybe a month or two early.

There appears to be a transference issue that needed to be addressed. The suggestion to end therapy was interpreted by the client as an indication that the therapist was tired of listening to her. Despite wanting to continue therapy, she obliged with the therapist's suggestion to terminate. It is likely that the unresolved transference continued to govern the client's belief system about herself and the way others respond to her. She dutifully complied with the therapist's recommendation to cease therapy, while secretly questioning and doubting the rightfulness of it. Just as an unnecessary prolongation of therapy often leads to an 'as if' therapy, the same 'false self' compliance to please the therapist can be activated in pre-mature termination.

Gabbard (2007) makes another interesting interpretation that prematurely suggesting that the therapy should end is the therapist's 'counterphobic' reaction aiming to evade guilt for exploiting the client for their own purposes, this being monetary or emotional gains.

Some participants experienced very difficult endings: "the end of therapy wasn't good. It was a truncated end, abruptly truncated end". Terminating therapy that one was dissatisfied with posed its own difficulties. One participant, despite not regretting termination of therapy, struggled with achieving closure. Her attempts at processing and resolving the difficulties with the therapist had failed. They were unable to reach a shared understanding of what precipitated the client's decision to end:

... it sort of occurred to me that ending therapy was actually maybe a sign of health. I mean, I didn't like the way that it happened, but to get away from something that had been helpful but maybe wasn't continuing to be helpful at that time may have in fact have been of some benefit, but I guess I was sort of very confused because of the process of how that happened. You know, to be clear about what was good and what was not good was a bit wobbly, a bit unclear.

She furthered explained that:

the unhappiness with therapy came at the point where I declined to continue attending, but I did have a couple of attendances around trying to get some understanding of that to see whether it was possible to repair .... I mean, I am happy with my decision to not continue on with that therapy because I don't know whether it was helpful .... the unhappiness ultimately was at that penultimate session.

Another very important issue, indicated by this participant, relates to the process of mourning the end of therapy. Cases, in which the end was abrupt, made the transitional phase and mourning very difficult for the client. In this, and other similar situations, an unresolved termination was likely to leave the client with complex residual feelings of anger, resentment, and guilt about disappointing the therapist, and a growing certainty that early termination was a mistake. Research on the post-termination phase conducted by Craige (2002) revealed that clients typically experience a sense of loss of their therapist and struggle with the process of mourning the therapist. Similarly, Orgel (2000) describes the termination phase as the beginning of the process, in which the client mourns the loss of the therapist and struggles to create internalizations of the therapeutic relationship. These internalizations will support their capacity to manage a life that must be faced without the therapist's guidance.



Endings were often very difficult for participants and frequently postponed and ‘eased into’ by moving to a ‘maintenance’ stage, in which clients could stay for a long period of time, seeing the therapist once a month “just to touch base”. Some participants felt they must engage in a gradual reduction of the sessions as a way of ‘testing the waters’, before making a final separation and found that a periodic consultation was the best course. Others stated that they realized that they might need only occasional appointments every six months or so, but they knew their therapist would be there for them if they needed them. Research indicates that it is commonplace for some clients to engage in intermittent therapy, where they return periodically for therapeutic work based on particular issues triggered by life events (Gabbard, 2007). This is in line with the suggestion that, for some clients, a model based on the family doctor whom one consults when necessary, may be far better than a radical separation (Thomä & Kächele, 1994).

In some instances however, participants wished to terminate therapy because they felt that the goals of the therapy have been accomplished:

I can still go and be surprised sometimes by the intensity of a discussion .... I mean I still like that ability to have that psychological richness, but I don’t feel it as a need in the same way.... it is an interest, and probably if I had unlimited money I would go every week just for the fun of it. Maybe I would, but ... it was a sense that ‘This shouldn’t be a self-indulgent exercise’. I did go for a particular purpose. That purpose I think has been really well met. But there are all sorts of things that I would still like to explore with her, but the reason for which I went has been addressed. And I think the test of it, I suppose, will be the extent to which I’m able to deal with subsequent significant changes, but I think so far that has proved successful.

Here, the time to end therapy came when certain specific issues or symptoms were eradicated sufficiently to participate in life in a more confident way.

Termination and post-termination are the least understood phases of treatment (Craig, 2002; Orgel, 2000; Schlesinger, 2005). Much of the existing literature on termination is based on theorists’ and researchers’ assumptions of how clients are expected to end therapy (Salberg, 2010). The current research offers some insight into the client’s perception about the ending of therapy and its significance to the process of recovery. This material may help to challenge assumptions that ultimately constrain therapists in their practice. Terminations commonly elicited high levels of ambiguity in clients. In order to successfully negotiate terminations, the therapist needs to retain a certain level of open-mindedness and receptivity to the uniqueness of each therapeutic encounter. It is also important to address clients’ fulfilled and

unfulfilled expectations about the outcome of therapy and allow sufficient time to work through the client's feelings regarding the loss of the therapist.

On the whole, the material discussed by clients' serves to remind therapists' that treatment termination presents clients with extraordinary challenges. They are often filled with anxiety about transition into a stage where they need to rely on their own ability to tolerate and master internal and external stresses, without the support of the therapist. Terminations are not only difficult, but also imperfect; they are by and large idiosyncratic and while there may not be one prescriptive management strategy, there is certainly great need for the therapists to think carefully about possible termination. The experiences described by the participants in this study indicated that the therapists, on the whole, dedicated insufficient amount of time to discussing termination with their clients. The participants typically wished for greater acknowledgement of the significance termination had to them, often felt unprepared for it, and wished for much more time being spent on that final phase of treatment. Overall, the key message is that the end of therapy holds great significance to clients; it is an end to a very important relationship and requires careful preparation. It is a very complex process unique to each therapist-client dyad, but it is a phase of treatment, not a singular event, and therefore should be treated with just as much consideration as any other phase of treatment.

This chapter focused on identifying clients' perceptions of helpful and hindering aspects of therapy. The examination of their experiences provides a direct window into what can facilitate or interfere with change, which in turn may lead to a better understanding and, ultimately, the improvement of psychotherapy. Key results from this study indicate that strong therapeutic alliances, secure therapeutic spaces with solid boundaries, and therapist's provision of developmentally significant function were recognized as having the highest significance in promoting therapeutic change. Change facilitating strategies, being it model specific or universally present across treatment modalities, were found to be of significance; however, they were given secondary importance over primacy of a strong therapeutic alliance, which was consistently recognized as a core helpful factor in generating positive therapeutic change. Such perceptions of helpful events in psychotherapy is largely in line with the findings of process-outcome studies, indicating robust correlations between alliance and improvement (Castonguay et al., 2010; Pascual-Leone & Greenberg, 2007). Previous studies (Elliott & Shapiro, 1992; Hardy et al. 1998;

Labott, Elliott, & Eason, 1992), showed that clients ascribe more value to relational dimension of therapeutic events, whereas therapists typically placed more value on the client's cognitive insights. The categories of strong therapeutic frame and therapist as developmental object were not previously reported to be of significance to the clients. These findings have been confirmed in the psychotherapy literature, particularly of psychodynamic and psychoanalytic persuasions, but were yet to be recognized as universally helpful to the clients across therapeutic modalities.

Participants in this study identified a number of therapist-related factors that may interfere with or negatively impact therapeutic change. These were present across various therapeutic orientations and included therapists' routinized approach to their clients, which was typically expressed in excessive reliance on diagnostic and treatment preconceptions, often mechanically applied to the clients' complaints, as well as establishing goals prematurely, often without consultation with the client. Harmful effects in psychotherapy were also associated with inefficient application of technique, which was typically expressed by inaccurate interpretations as well, as an imposition of excessive structure or lack thereof. Other therapist-related behaviours frequently reported as detrimental were misattuned therapists, fear of being judged by the therapist, and a lack safety in the therapeutic space. This is in line with previous studies showing that judgement, blaming, and other forms of hostile control, as well as limited attunement and limited understanding of the clients' needs lead to poorer outcome (Constantino & Smith-Hansen, 2008; Casonguay et al., 2010; Henry, Schacht, & Strupp, 1990). In addition, participants discussed various difficulties arising at termination highlighting its complexity and importance of paying much greater attention to this phase of treatment.

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## **CHAPTER Seven**

### **Significant Moments**

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This chapter summarizes the findings pertaining to the participants' experience of the significant moments. In the first instance, the participants described their overall experience of change as a continuum without any specific points of transition. However, when asked directly about any turning points or decisive events, some participants were able to identify a number of experiences that had a transforming and empowering effect. One of the possible explanations for this inconsistency could be that significant micro-events or specific sensory or emotional experiences might be difficult to recall with the passage of time. While spontaneous recall did not occur, when prompted, participants were able to provide vivid accounts of these events. In essence, the findings presented here show how these events were remembered and what meaning is ascribed to them post-therapy.

Significant moments in therapy are moments when the clients spontaneously understand something new and significant about their own or others psychology and experience. These are moments when something suddenly shifts or changes, causing reformulation of information in a new, often surprising, and clear way (Hill & Corbett, 1993). These moments, while uniquely significant and meaningful for each client, commonly produce feeling of aliveness, interest, and vividity. The analysis of the current data generated two distinct clusters including: transforming experiences, and empowering experiences. Amongst them was the high prevalence of relationship-oriented events, including 'feelings validated and owned', 'therapist's disclosures', and 'changes in the relational self'. This reflects existing research findings, indicating the therapeutic relationship to be crucial in generating positive outcomes in therapy, irrespective of type of therapeutic intervention (e.g., Frank & Frank, 1991; Krupnick et al., 1996; Horvath & Bedi, 2002). However, a high prevalence of affect-oriented events such as 'deeply felt emotions', 'honesty and

realness’, and ‘experiencing self at deeper levels’ may suggest that, while the relational context is central in generating positive change, it is the affective experience that fuels and sustains it. The current study also suggests that these experiences, while described as ‘moments’, are not momentary instances isolated out of the larger and more complex structure; instead they are a cumulative product of experiences developed over time, out of complex processes requiring multiple repetitions. Findings from this study indicate that these affective experiences, repeated in a reliable and safe relational context instituted psychological change. Table 12 details the major themes to emerge from the analysis.

Table 13. *Significant Moments: Frequency of Occurrence of the Theme*

<b>Transforming experiences</b>	<b><i>Typical</i></b>
Moments of insight	<i>Typical</i>
Moments of integration	<i>Typical</i>
Deeply felt emotions	<i>Typical</i>
Honesty and realness	<i>Typical</i>
Therapist’s disclosures	<i>Typical</i>
Small realizations	<i>Variant</i>
<b>Empowering experiences</b>	<b><i>General</i></b>
Owning and validating feelings	<i>Typical</i>
Self-assurance and inner strength	<i>Typical</i>
Changes in relational self	<i>Variant</i>
Regaining future orientation	<i>Variant</i>

General: all cases or all but 1, Typical: more than half; Variant: less than half; Rare: 2 to 3 cases

### **Transforming Experiences**

Participants identified moments of transformational value within their interaction with their therapist. These experiences induced transformation from a ‘disembodied’ to an ‘embodied’ state, effecting change in the experience of self and other. The analysis of this material offers an insight into the mechanisms of these change-inducing processes. Here, the main composites included aligning of the cognitive, affective, and bodily level responses, which when repeated over time, in the presence of understanding and reflective therapist, led to change-inducing

insights. These repetitive experiences established a positive feedback loop between therapist and client over time instituting change.



*Figure 20.* Transforming Experiences.

**Moments of insight.** Generally, moments of insight were described as sudden realizations that were accompanied by a sense of euphoria or enlightenment. Common expressions included: “turning on a light bulb”, “the classic heart moments”, “little enlightenment moments”, “self-reflective moments”, “the moment of acknowledgement”, “moments of sudden revelation”, and “Aha moments”. These experiences were frequently accompanied by statements such as: “It was like when you put the last piece on the jigsaw puzzle”; “My god! I can see this. I understand it”; and “suddenly it was like the whole thing got turned around”. One participant spoke about these moments of insight as a “sensation in the body of just knowing. It is like suddenly fragments become whole; that sense of knowing”. Others described these moments as intense feelings of “internal fires, internal flame”, which led to “feeling full emotionally and spiritually”; and “It wasn’t sharp but it was a jolt almost... like a discharge. It almost felt like I got some energy back but it was very positive. It was really intense for me, this whole experience”.

These instances were seen as an indispensable part of the learning process: “these really were a learning experience, learning about myself, learning about perspective”. Participants also recognized that such moments would bring hope and excitement, exultation and enthusiasm, as well as relief and freedom. One participant acknowledged that these moments lead to a greater feeling of freedom. Domash (2010) refers to those sudden bursts of realization as the “embodiment of unconscious freedom” (p. 316), that is, moments when spontaneous understanding is

achieved when previously dissociated or repressed material is brought into consciousness.

However, there was little consensus in terms of the therapeutic processes that precipitated these moments of insight. Instead, participants listed a variety of precipitating factors including deeper relaxation or hypnotherapy, psycho-education, the right timing, and the therapist's ability to see the 'bigger picture' and recognize the underlying meaning. These moments were also facilitated by the use of silence and space:

There were moments in the session where he was just looking and I was just looking back and I realized that I just didn't know what to do with my eyes. I sort of felt as though I had no boundaries and that my eyes were kind of locked ... It was a profound moment and I think I saw myself differently because I realized that I had boundary issues, or issues around self and other and understanding the difference between me and others and feeling confused about spaces between me and others. So from that point on I really noticed the subtle ways that I don't honour my boundaries ... and that all came just from silence and eye contact. I felt like an ant under a magnifying glass, almost like a burning sensation.

This quote illustrates how understanding emerges out of the experience. Becoming aware of boundary issues, or in this case, separateness from others reached consciousness in the process of having a close personal encounter with the therapist. There seems to be a paradox, in that, being with the therapist afforded the client a unique experience of separateness. She had a new internal experience through participation in that wordless exchange in which the therapist's presence provided a proxy body boundary. As a result of this experience, she came to her own body and was able to have an embodied sense of herself in relation to another person.

Others concurred that such moments were experienced as intense and emerged out of deep work: "she made me realize and made me think about things, probably a lot harder than I would have thought myself". These moments developed out of deep interpersonal interaction which produced an understanding that ultimately united affect and cognition:

It was just absolutely illuminating.... I don't know that I would have come to that realization if we hadn't had these intense encounters .... And although intellectually I had done that ... emotionally it just hadn't translated, so it was about bringing together the mind and the emotions again.

Several studies have shown that, when recalling significant events, clients emphasize the emotional correlates and the relational context; in particular, they focus on the therapist's attitude towards them and the issues they are attempting to resolve (e.g., Elliott & Shapiro, 1992; Hardy et al., 1998). Another indication that clients prioritize

their emotional experience comes from a study conducted by Labott, Elliott, and Eason (1992), in which, despite recognizing the helpfulness of therapeutic interventions, clients terminated therapy when they found the experience emotionally uncontained and difficult to manage.

One of the potential explanations, as to why clients terminated therapy when their emotional experiences remained uncontained, is that it only exposed them to painful feelings without reaching any substantial resolution. That is, even when cathartic, these moments did not develop into contained and consolidated understandings. Here, clients were most likely left with uncontained painful memories. Castonguay and Hill (2007), address these dynamics in their theory of integrative insight. They postulate that intellectual insight has only limited change-inducing capacity. Following earlier theory of Wachtel (as cited in Castonguay and Hill, 2007), they argue that intellectual insight may even have a defensive function, in that, the insight allows for the avoidance of experiencing affects. This is contrasted with emotional insight, which has greater change igniting capacity. They further distinguish emotional insight from catharsis or abreaction, which typically generates only temporary relief (Castonguay & Hill, 2007). Because it also contains a cognitive component they named it integrative insight; that is, an insight that contains both, emotional experience and intellectual understanding: “when patients experience integrative insight, they are able to grasp cognitively the causes of their conflict and problems and simultaneously experience feelings that had not previously been in awareness and attached to this cognitive understanding” (Castonguay & Hill, 2007, p. 296). Thus, internal conflict can be illuminated in a new way when emotion and cognition undergo integration. This integration would have been missing in these instances where emotional experiences were uncontained. Building on Castonguay and Hill’s theory, the current data indicates that insights are truly change inducing when experienced as a multi-dimensional process of alignment in the cognitive, affective, and bodily domains.

Descriptions of study participants offer a unique window into what happens during these transformational moments. They strongly indicate that insight of transformational value required activation of physiological, affective, and cognitive levels. The following participant articulated how activation on one level produces response on another level, and how this intertwining leads to conscious experience that brings a sense of clarity:

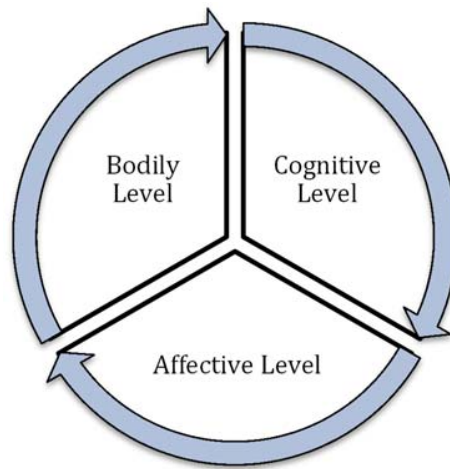


Common about these moments was introspection and ... a physiological response ... a small burst of endorphins, certainly a physiological feeling of feeling good and a cognitive response of clarity or being able to see how things relate, such as my own history and my own biases and response tendencies and others, or it was just an insight about myself and then having clarity about my own thought patterns and affect response patterns as well .... Even if a thing is negative, it's still feels like there is a slight physiological response of there being ... a chemical reinforcement ... a sense of almost a rush, a small rush of energy through the body .... I would associate something similar to that in having those insights, even insights into the reality that you may have been wrong or you may have an unhelpful tendency to do things. And I think that might be called hope—...—... because even having an insight that you're wrong provides hope that you can change and that you can act in more accordance with how you want to.

Others spoke about these moments in a similar way, as a “physiological rush, as well as a thought process of very clear connections between concepts”.

Interestingly, in their recollections of moments of insight, participants emphasized the ‘bodily felt’ level of experience over its cognitive counterpart. This could be theorized as a ‘chemical cure’, in which an activation of a neurochemical response in the brain is of such intensity that it can ‘break’ into consciousness and produce insight. In other words, alignment of the bodily, affective, and cognitive level reactions generates a strong response, which emerges into consciousness and produces moments of clarity. This speaks to the complexity of the process that generates insight, as involving alignment and integration of different levels of information processing. It would appear that when this process is re-experienced over time, it generates a stronger interactive loop between these three levels and breaks into consciousness as an integrated stream. Thus, change-inducing insight primarily occurs when strong affect, body experiences, and cognitions are integrated and recognized on the conscious level. Figure 21 illustrates the proposed interaction between these three levels.

Such process is understood here, as instituting a re-vitalizing psychochemical change. Drawing from this data, the model of change inducing insight was developed (*Figure 21*).



*Figure 21.* Model of Change: Inducing Insight.

Some connection can be made between the model proposed here and Martin, Paivio and Labadie's (1990) findings, that moments of significance were characterized by a much higher level of information processing than other events in the session. This is congruent with participants' experience of 'chemical reinforcement', which is suggestive of a general increase in neurochemical activity within the brain (Corrigall, Payne, & Wilkinson, 2014). This neurochemical perspective resonates with the analytic concept of 'mutative insight' (McLaughlin, 1988; Ryan, 2007). Such growth-generating insight needs to emanate from both an intellectual understanding and an emotional unconscious process, usually characterized by struggles of high emotional intensity. Khan (1996) refers to these moments as moments of self-experience and explains why cognitive level insights on their own are insufficient to generate change: "Interpretation, as such, cannot engender self-experience in the patient, although, once these experiences actualize, interpretations enable the patient's ego to find and elaborate symbolic equations through which these experiences can become a property of the inner psychic reality of the patient-conscious and unconscious" (p. 295). He stresses that actualization of self-experience is strictly connected with the body-ego dimension, and provides an evocative illustration of this point by quoting Balint's (as cited in Khan, 1996, p. 296) clinical case of a young woman whose main complaint was an inability to achieve anything:

...apparently the most important thing for her was to keep her head safely up, with both feet firmly planted on the ground. In response, she mentioned that ever since her early childhood she could never do a somersault, although at various periods she tried desperately to do one. I then said: 'What about it now?' – whereupon she got up from the couch and, to her great amazement, did a perfect somersault without any difficulty. This proved to be a real breakthrough. Many changes followed, in her emotional, social, and professional life, all towards greater freedom and elasticity.

There appears to be a distinct trajectory for change-inducing insight, beginning with the activation of the bodily/felt, followed by the affective/emotional, and finally the cognitive/intellectual level. When this process is repeated over time, it allows for a consolidated multi-level understanding responsible for lasting change. One participant expressed this process in the following way: "consolidating bits of insights and understanding that I have in myself [developed] into a more robust concept .... this made me feel peaceful and proud of myself for being able to have that moment ". Participants also indicated that this type of consolidation required the therapist's presence: "...when I am having a moment of insight and the therapist is understanding that I am ... that feels real". This suggests that the therapist's understanding presence and ability to reflect this to the client, is what binds this process into a 'real' and 'alive' experience, which can continue growing and inducing change. This form of 'understanding presence' goes beyond the alliance on a verbal level, into a more spontaneous, non-verbal interaction. Neuroscience indicates such non-verbal interactions accounts for 90 per cent of communication (Soth, 2006).

Moments of insight may require specific conditions to be consciously experienced and, as such, may have a delayed effect. The following example illustrates that these moments might imprint themselves in the client's mind awaiting the right time to be recognized and consolidated into the larger structure:

I didn't really pick up at the time, but the thoughts won't go ....I can remember the moment still years down the track, and I think those sorts of moments are interesting because you might be rebelling against everything in your head, but sometimes something just hits and you know it is there. You can still ignore it; you can ignore it for years. It was a significant question which I outwardly denied and ignored, but which just stuck.

The sudden moments of insight are explained by neuroscience as a right brain phenomenon, in which the emotional, spontaneous, and intuitive aspects of mind bypass rational thought and allow access to the unconscious, thereby producing a new or different idea (Domash, 2010). Beeman (2005) explains 'aha' moments as a

sudden burst into consciousness of previously unconscious activities. Schore (2007) adds that these moments occur when anxiety levels are lower, as anxiety easily drowns out the neural signals necessary for insight. Complementary research conducted by Lehrer (2008) suggests insight can be a product of a very relaxed, anxiety-free, and focused state of mind, but also an intense, urgent state of mind. Similarly, Limb and Baum (2008) argue that current neuroscience indicates the ingredients necessary for sudden insight, including focus, suspension of judgment, and a relaxed state of mind. It is this state of mind that allows implicit material to suddenly become explicit, the state of mind that “formulates the unformulated” (Stern, 1997). Thus, in the moment of insight, the client is liberated from a fixed way of thinking and begins to see something new. What is changing is not just the thinking; it is the underlying structure, described by Fonagy and Target as change in a “key part of the architecture of mental life” (2007, p. 426). These research findings can explain why it may take a very long time for certain insights to become fully integrated into the body-mind structure. Like in the previous example, until the client’s mind was able to suspend judgment, remain focused, and relaxed, certain material had to remain unconscious and unintegrated.

On the whole, when describing moments of insight participants talked about changes occurring on the bodily, affective, and cognitive level. Their retrospective recall showed that those ‘aha’ moments were steeped in somatosensory experiences. A number of recent theoretical developments refer to this process as the ‘embodiment of mind’ (Clark, 1997), ‘embodied cognition’ (Fonagy & Target, 2007), and ‘enactive mind’ (Damasio, 2003). This notion of embodied cognition began with Freud’s idea of the mind as expressing itself through bodily referents, which he described as “the ego...is first and foremost a body-ego” (as cited in Fonagy and Target, 2007, p. 424). Reflections from the current study illustrate what Fonagy and Target named as a move from ‘disembodied information processing’ to the ‘embodiment of the mind’. For the participants, these moments of insight were experienced as psychological growth emerging out of their own psycho-physiological structure; it was a multilayered sensory, emotional, and cognitive experience. Clark (1997), as well as Thompson and Varela (2001), support this notion, arguing that any separation between cognitive and physical manifestations is artificial, and that it is the link of brain and body that creates mind and consciousness. Clark (1997) further argues that meaning can only be acquired

through cognition that emerges from embodied action, when emotion, mood, and motivation are aligned with cognition. Another way of looking at this phenomenon is Damasio's (2003) concept of 'core consciousness', which he sees as the foundation of our sense of self. According to Damasio, this basic sense of self develops at the interface between signals on the bodily, affective, and cognitive level, and signals from the outside world.

**Deeply felt emotions.** Typically, participants acknowledged the transformational value of deeply felt emotions. Deep emotions were defined by one of the participants in the following way:

Raw is probably one of the only words that I can have for it. It is not rational or logical or reasonable. It is there, and I couldn't rationalize it. I couldn't put a process behind it or give meaning to it. It was just there, and it was quite overpowering. These moments, while promoting new understandings also generated an internal sense of freedom. Another participant explained these moments and their significance in the following way:

I'm not a terribly teary person as a rule, but it would just really catch in your heart space. You would get this emotion that came from a really, really deep spot. It was just that letting go, of getting the emotion actually out there and letting it go, or feeling it and being safe in the feeling of it, which was important too.

In some instances, deep relaxation brought on these moments: "I felt like she had tapped right in to my inner thoughts and inner everything ... and I just let everything go, and it was such a relief. That was probably the deepest thing". Some participants claimed that these experiences were only possible in therapy. One participant gave an evocative expression of these deeply felt moments of healing: "It felt like someone has touched my soul as no one has ever before, and has actually touched it and said, "It is okay. It's not just okay, it is actually beautiful .... It is just right the way it is". Here, the importance of the therapist's unconditional loving acceptance of the client's core-self was emphasized.

This process is theorized within the self-psychology perspective as fulfilment and internalization of previously frustrated or unmet needs, leading to a much greater self-acceptance and self-love (Rogers, 1961). Kohut (1971) theorized that the facilitative nature of this process rests on the therapist's ability to develop the self-object transference, which promotes the client's re-experiencing of unmet early self-object needs, allowing a second chance to complete psychological development. Based on the insights offered by these participants, the following trajectory seems to occur: the therapist's unconditional positive acceptance enables the client to come

into contact with disowned parts of self; this often culminates in significant moments with deeply felt emotions; sharing these moments with an accepting therapist leads to a qualitative transformation of the disowned parts of self; and the therapist is subsequently internalized as a self-loving object. The importance of the therapist's mental attitude was emphasized by Elliott and Shapiro's (1992) research, which showed that it was the therapist's empathy and ability for evocative empathic reflection that generated and integrated the client's moments of insight. It needs to be stressed however, that these significant moments occurred as a result of careful and lengthy clinical work that enabled the client to gradually expose all aspects of self.

Transformational moments were more likely to occur when clients recognized them as aligned with their views and values: "I may have had a strong emotional response where I was able to connect that with my own values and beliefs; I felt those moments deeply". Here, the therapist is not imposing his values, but instead helping the client to connect with his or her own values and beliefs and this subsequently generated a greater sense of aliveness and self-integration. This reinforces the critical role of the client's own theory in producing positive change, as well as the therapist's ability to adapt the interventions, so they match with or are closely aligned to the worldview of the client. There is a large body of research suggesting that tailoring treatment to the worldview of clients is associated with positive change (Lambert et al., 2003; Norcross, 2002). Some studies showed that the match between client and therapist perspectives increases with a strengthening of the relationship (Kivlighan & Arthur, 2000). Therefore, in successful therapy the therapist may become more attuned to the client's ongoing experiences, and more capable of aligning interventions to the client's subjective experience, congruent with their values and beliefs.

In some instances, significant moments of deeply felt emotions contained a formulation of the client's theory of change. It was the felt experience of deeper, more infantile parts of self. The quote below illustrates the client's awareness of the need to work therapeutically with earlier, less developed parts of self:

It was vital for me because that is the level I needed to work on. I think it just depends, but for me it was very much that I could say the right things, I could do the right things - it is that really internal world that didn't match with any of my life as such, as in now at this stage of life, and being able to manage a whole lot of things, but that internal world just won't let you go, still being very infantile.

Participants frequently stressed the importance affect played in psychological growth. They offered descriptions of the sequence of events that occurred with depth and intensity of affect and the effect this process had on them. Initially, it was important to allow space for the emotional experience: “not even necessarily was it verbalizing them [emotions] or processing them. It was learning to sit with them first, then getting to an understanding of why they were”. In this first phase the client began accessing the emotional level, which was dominated by unspecified, unqualified felt experiences. This description is consistent with Damasio’s (1999) distinction between emotions and feelings; he describes feelings as the product of emotional states. That is, feelings are narrower expressions of much deeper and broader activation within the emotional space. It would appear that if the self can be activated and experienced from these deeper levels this would subsequently lead to a decrease in defences, greater spontaneity, and increased ability to observe one’s own reactions:

It was such a deep dynamic going on that it would really touch you deep inside and it makes you feel, ‘Wow! How am I reacting?’ You are just observing your own self in that sort of situation and you just love that something took control of you and you just do things out of the blue. And that is just so beautiful .... I had those significant times.

Positive change was generated via the process of coming into contact with oneself on a deep emotional level. Deep emotional experiences formed a platform for emerging new feelings and thoughts that were an expression of a real embodied self. There was a consensus amongst participants that moments of deeply felt experiences were fundamental constituents of positive change:

It is an important part of the process and to have that experience of change that comes with moving into that deeper sense of feeling ... and then it takes it to another level because you have a different perspective on yourself and the process. I think it is what brings about change. It is probably the point that change happens.

Tomkins’ (1962; 1963) early theorizing on affect and later work of Beebe and Lachman (2005) on co-constructive interactions shed some light on the therapeutic importance of these moments of deeply felt affect. In his pioneering work, Tomkins placed emphasis on the importance of affect as an ‘analog amplifier’ that makes any given state promoted by it last longer. Beebe and Lachman developed this notion into a co-constructed theory in which these ‘analog amplifiers’ are described as ‘heightened affective states’, which are activated when an individual experiences powerful states of transformation. States refer here to arousal and

activity level, facial and vocal affect, and cognition. When these heightened affective moments occur in the therapist-client interaction they offer an opportunity for new experiences. This often leads to dramatic, integrative, and altering transformations that organize experience into new themes (Beebe & Lachman, 2005). Such moments are jointly co-constructed by the therapeutic dyad and mark the beginning of a new possibility, a new kind of relating, lending itself to gradual transformation of a self-regulatory style. They explain the outcome of this process in the following words: “the therapeutic action of heightened affective moments is mediated through state transformations that potentially usher in opportunities for an expanded self-regulatory range and altered patterns of interactive regulation, thus new internalizations and therapeutic change” (p. 191).

Another excerpt, in line with these theories, illustrates how intimate exchange between the client and therapist can generate a ‘heightened affective state’, which leads to a dramatic transformation of the client’s affective state:

She said, ‘Oh come on, I’ll give you a hug’ and she gave me a hug. And it was the most powerful. It was almost like an energy exchange ... I can’t really describe it. It felt like it was a light into her and a light coming through me as well. It was almost an exchange. I don’t know whether it was almost like a discharge ... where she is holding some of my stuff

Schore (2003, p. 30) addresses the nature of such exchanges embedded within synchronized transactions, as generating a transition in two members of the dyad from a state of low arousal to higher arousal and into an intensely positive affective state. This, he understands as the dyadic psychobiological mechanism responsible for a “mutual regulatory system of arousal”. Trevarthen’s concept of resonance process also shades some light on how such powerful emotional states are generated (1993, p. 60). He explains that if the visual, auditory, and gestural patterns in two individuals achieve a stage of resonance with one another as “minds in expressive bodies”, this could lead to the immediate registering of action, which subsequently becomes imprinted. This suggests that positive change is generated when the therapist can cognitively and viscerally register affective states produced by the client and process the experience within a mutually synchronized and aligned exchange.

Contributions of modern neuroscience into the field of psychotherapy by Panksepp (1998; 2010), alongside Damasio (1999; 2003), Schore (2011), Turnbull and Solms (2007), and Trevarthen and Aitken (1994), have focused particularly on



affective states, as they emerge from the neurodynamics of the brain. These studies are of outmost importance, because they allow for concurrent investigation of affective experience, behavioural and bodily changes, as well as neural changes. Neuroscience has confirmed clinical and theoretical intuition that the affective states are at the heart of human functioning and that any lasting psycho-behavioural change requires reactivation and reworking of these deeper structures. Watt (1999) argues that the “emotion binds together virtually every type of information the brain can encode...[it is] part of the glue that holds the whole system together” (p. 1). Similarly, Panksepp posits that feelings precede thinking, and that thoughts are channelled by emotional and motivational processes, some of which are conscious whereas others are not. He stresses, “a great deal of brain activity is devoted to creating the affective infrastructure upon which our cognitive abilities are built” (1999, p. 34). He further emphasizes that frequent cortico-cognitive activities in humans result in suppression or heavy modulation of sub-cortical emotional processes; this could explain why it is common for people to be unaware of powerful feelings. Thus, it is of outmost importance, that the therapeutic interaction centers itself on recognizing the reality of feelings, which through talking to another can be brought to awareness and felt in an embodied way.

**Honesty and realness.** Typically, participants considered moments when they felt the therapist’s realness and honesty as highly therapeutic. For some, these moments occurred with greater frequency than for others: “most of the time, I mean that was the value of it”; and “there were very few times where it felt anything but real”. These moments were comprised of truthfulness: “there were no punches pulled and I personally value that in therapy ... another thing really important for me to know is that the therapist is willing to tell me the truth”. They also had a quality of “subtlety and lightness”. As one participant pointed out, these were moments in which “both people are sharing the same reality”. Another dimension of realness was “sitting with mutual vulnerability and imperfection” or as another participant said, “there were those moments ... we were just two people each with our own inadequacies”. Times of felt honesty and realness lead to alignment and reciprocity of experience:

There was this one moment where she said something about my parents and it came from the heart ... There were times where she might say the right thing at the right time. ... when you catch someone’s eye and it is just that, ‘Oh!’ She would look me

straight in the eye and it would just be one comment and it happened to be the right thing.

In this case the essence of the communication between the therapist and client rested on emotional authenticity. This participant described an instance of the therapist's communication of emotional truth as having a highly generating an igniting effect. The importance of emotional realness and openness has been emphasized by various humanistic and relational therapy approaches as central to the therapeutic relationship. Authenticity is seen as a necessary catalyst for client self-disclosure, trust, self-knowledge, increased intimacy, and psychological change (Tantillo & Sanftner, 2010).

Humour was also recognized as one of the vital constituents to moments of realness: "little jokes that no one else would get, but it had been something that had come up in therapy and you could share that, those little moments"; and "I should think laughing sometimes, those can be real moments". The value of these moments was in allowing the clients to be themselves: "I have got sort of a funny sense of humour and I was able to be myself with him and he would sort of smile". They also helped participants to feel understood at a deeper level: "it was almost like a real feeling of being understood and got at some really deep level. ... not always funny and humorous but also quite touching when I think about it now". Laughing was considered to be an experience were two people were real as they were sharing the same reality:

A moment of being able to laugh together. I think it requires the therapist letting their guard down and having an honest reaction rather than a neutral face, and that happened more with some therapists than it did others ... laughing about the predicaments we find ourselves in and being able to relate to it as people ... I find that helpful from a therapist .... it is soothing, it makes you feel like you are not under investigation, that that person knows where you are at; they have been where you are at. They get you, maybe they like you; that is pretty important actually, feeling as though they get who you are and they look forward to your sessions maybe because they can connect with you as a human being.

The current data suggests that humour in therapy is seen as a very important marker of realness. Descriptions provided by participants showed humour arising from the use of living language in the moment, while injecting spontaneity and vitality into the therapeutic exchange. The use of humour in psychotherapy has been receiving increased attention from researchers and theorists (e.g., Buckman, 1994; Nilsen, 1993; Ortiz, 2000; Richman, 1996; Saper, 1987). Ortiz, in stressing the value of 'being oneself', acknowledged that adopting a humorous approach to interaction

allows for greater openness and connection with clients. Others also support the use of humour in therapy as a means of promoting intimacy, humanness, and directness, and subsequently a closer, more informal working alliance (Bloch & McNab, 1987; Poland, 1971).

Freud (1916) understood a joke to be a thought aimed at reactivation of childhood states of mind. Humour arising in the therapist-client dyad could be seen as phenomenon occurring in the transitional space described by Winnicott (1986), as the potential space for play, interchange, and shared reality. In other words, a spontaneous use of humour could promote the use of the transitional space in therapy. Rozenheim and Domash (as cited in Haig, 1986, pp. 547-549) have described constructive aspects of humour as promoting a number of facilitating processes, including: 1) the formation of the therapeutic alliance, in that it furthers experience of naturalness and intimacy and facilitates more gratifying interactions with others; 2) the facilitation of breaking through and freeing resistive defences, enabling contact with unconscious processes; 3) moderation of excessive anxiety; 4) as an 'affect releaser' as it promotes emotional expression and catharsis; 5) building ego strength 6) fostering the self-observing capacity, as the ability to share in humour requires some level of detachment or standing outside of oneself. Another way of explaining why moments of humour play a very significant role in therapy is Beebe and Lachman's (2005) theory of 'heightened affective states'. They postulate that the therapist-client interactions, while generating humour and surprise become a heightened moment, serving as an affect organizer for both participants. These are heightened moments because they require the therapist to join with the client in moment of shared relief from tension.

Participants also recognized realness in simple gestures that sometimes occurred outside the scope of therapy sessions: "in pre- and post-session general chit-chat that is not necessarily on therapy that felt very real as well". These sometimes served as an adjunct the therapeutic work:

Things that really moved me in therapy were sort of human gestures ... one day I had come to the end of a session and it was absolutely throwing it down with rain and I didn't have an umbrella and she offered me to take an umbrella .... so little things like offering, for example, if she was going on a particularly long break and depending on how intense the therapy was, sometimes she might offer me a little memento or something from her office ... just to carry or keep with me as like a transitional object.

Such extra-therapeutic gestures meant a great deal to clients, because they were outside the therapeutic contract. They arose from the sheer willingness of the therapist, which was not part of the 'paid-for-hour' interaction. These moments further facilitated dissipation of the asymmetry in the client-therapist relationship, without compromising therapeutic boundaries:

I said, 'I just want to give you a hug because I just feel that you have done so much for me' ... So, I gave her a hug and that was very significant because although I felt warm and connected to her there is always that professional personal distance ... and I just felt that was a little bit of her personal side coming out, which I felt great that I actually was able to share a little bit of her personal side.

Therapists' mistakes were perceived as another expression of realness: "even if she, ... was a little off the mark or contributed something that wasn't as helpful, it was still real. It was, still, that she was demonstrating that she was human and she was making an effort and trying to work with me, and that really matters". Thus, what leads to productive therapeutic change is not the illusory and omnipotent image of the therapist, but rather an experience of being with someone who, while truly committed to helping, is not free from making mistakes.

**Small realizations.** Some participants perceived transformational experiences as deriving from the cumulative effect of small moments of realization of insight. These experiences were captured in the following statements: "little leaps", "chipping away", "gradual realizing", and "smaller moments and lots of them". Some participants described this process in the following ways: "For me in therapy there weren't these sort of enormous 'Ah hah!' moments where it is like, 'Okay, I see everything clearly now.' It was such a slow gradual process"; "For me it was the little stuff that tended to trip me up every now and then"; and "It has been this kind of unfolding ... or illumination of things that made me feel different about myself and about other people". In some instances, these small moments of realization had an effect of "moving forward, moving away from the fear based emotions ... a little bit of escape from those". One participant described a 'small moment' that led her to have an emotionally corrective experience. Despite the fleeting nature this was a profound and therapeutically potent event:

She looked at me and said, 'A compliment is good' and all of a sudden ... it made me realize that if she said that, I would get really anxious because I would end up with guilt coming back from as a child. Something nice would always follow something - - Who knows what else is going to happen? And I found that really powerful to go, 'Oh! Oh all right, okay. Fair enough!' It seemed only a very small thing, a very small moment, but for me that was a really significant moment.

Another example illustrates how the client's own theory of change dictates the parameters in which positive change was likely to happen:

I don't think there was anything that particularly made me stand up and go, 'Oh my god! That's it! I'm cured' and walk out. I don't believe in that. That's why I don't believe in Tony Robbins and stuff like that, because you feel great for a couple of weeks afterwards and then you go back to your same habits. ... habits are habits; they are difficult to change. ... I think those little leaps are the significant moments, but I think it is lots of small ones, rather than any big one for me.

The material discussed in this section is highly significant to an understanding of the process of change. In describing moments of 'small realizations', participants indicated that change was accomplished through repeated interactions that helped them slowly change over time. This finding resonates with Kohut's (1984) concept of *transmuting internalization*. The process of change as follows the pathway of transmuting internalization, in which structural transformations do not result from intellectual insights, but instead come about as gradual internalizations of old experiences repeatedly relived in the current therapeutic context by the client's more mature psyche. Transmuting internalizations gradually establish the internal structure necessary to tolerate frustrations, delays, and gratification of needs. This leads to the gradual incorporation of therapist-client mutual interactions into the fabric of the client's self-concept and as suggested by Deitz (1992), this also occurs on the neurobiological level by affecting the structure, function, and activation of the amygdala-hypothalamic pathway.

**Therapist disclosure.** Therapists' self-disclosure is a contentious issue in psychotherapy, with some theorists advocating its usefulness and others indicating its interference with the therapeutic process. For example, the feminist tradition sees self-disclosure as a necessary component of therapeutic change (Mahalik, Van Ormer, & Simi, 2000). Similarly, within the humanistic tradition (e.g., Rogerian, existential, gestalt, cognitive-affective, interpersonal, systemic, and family therapy) the therapist's genuineness and openness are valued; therefore, the therapist's self-disclosure is supported as a therapeutic tool (Tantillo, 2004). On the other side of the coin, within parts of the psychoanalytic field, there are strong opponents of any self-disclosure (Bridges, 2001; Maroda, 1999; Renik, 1999). Opponents argue that the major risk is in drawing the therapeutic interaction into the real relationship, thus distorting the therapeutic alliance, compromising transference expression, and

weakening overall effectiveness of therapy. However, as Meissner (2002) points out, even within the analytic literature, views are polarized. Some see therapist self-disclosure as liberating the therapeutic dialogue and as such being essential to facilitating therapeutic process (Davis, 2002; Orange & Stolorow, 1998; Stolorow & Atwood, 1991).

Participants typically experienced some forms of therapist self-disclosure as therapeutically significant, and indicated these were often moments of transformational value. For example, when the therapist disclosed some personal information or showed emotion, this was viewed as highly significant and therapeutic. One form of disclosure was expression of therapist emotions: “one of the most profound moments was when she was saying something about me and you could tell it really came from the heart because ... her eyes welled up”. Tantillo (2004) points out that in letting clients know how their experience affects them, therapists validate what was evoked in the client and promote greater confidence in their experiences. Echoing current findings, Barrett and Berman (2001) found that such therapist self-disclosure led to higher ratings of the therapeutic alliance and lower ratings of symptom prevalence. This form of self-disclosure was experienced as valuable by the participant who felt the resonance of the emotional content:

When I was talking about something really emotional ... we had the same shared emotion, meaning that when I was here I could see that she had water in the eyes and she would say, ‘I can remember mine as well.’ You could call it self-disclosure, but she didn’t say a lot. She did say, ‘Yeah, you know, this reminds me of my grandma because my grandma is not well as well.’ That was enough. ... and when I asked her questions she was willing to tell.

This participant stressed the therapist’s thoughtfulness and sensitivity in self-disclosing, by providing a minimal amount of information. Renik (1999) speaks about there being a fine line between self-disclosure within client-therapist interaction and a two-person transaction, which in more extreme situations can even become a ‘two-client paradigm’. Meissner (2002) also stresses the need for the therapist’s careful consideration of what thoughts, feelings, reactions, and personal details are to be disclosed. He warns against self-disclosures from taking precedence and becoming ‘more figure than ground’ and diffusing the asymmetry of the client-therapist relationship and making it unsafe for the client to process their own material.

Participants were very sensitive to the therapist's self-disclosures and often stressed the importance of it to be "well calculated and appropriately shared". This was further emphasized by another participant:

There is a level of emotional connection .... [the therapist] visibly got upset over a story that he was telling me, but what was really interesting for me was that he did it in way that didn't make me want to comfort him or look after him. It was just there. It was present. It was real .... It was okay for him to be like that and it was okay for me to be like that, to be affected by what goes on in our lives. So that was very real to me.

Here, self-disclosure appeared to promote realness and dissolved asymmetry between therapeutic participants for a moment, allowing for a shared experience, which was found to be therapeutic. This also seemed to foster a sense of mutual connection; within the perspective of relational therapy, this form of self-disclosure would be seen as helping move the relationship from a state of 'connection through disconnection' to a new state of 'mutual connection' (Tantillo, 2004).

Another participant spoke about the issue of timing and the dilemma of cost and benefit of making self-disclosing statements prematurely:

One thing my therapist did somewhat later in the therapy was to acknowledge some of his personal issues, which for me was helpful. I don't think he was a bad therapist. I wouldn't have kept going to someone for four years or more than four years that didn't seem okay, but maybe he could have commented on that sooner, although I mean at the same time that I say that I am also mindful that you need a certain depth of relationship for his self-disclosure to have the right kind of meaning ... it has to be in a context.

Here, the adequate ground for certain types of self-disclosures was stressed. This participant clearly emphasized the importance of the solidity of the therapeutic dyad, as a factor in advantaging self-disclosure. The therapist-client relationship needs to have enough strength to be able to withstand the risks arising from deeper personal exchanges.

Some participants found therapists' self-disclosures of in-session reactions and responses highly valuable:

I think part of his technique as a Gestalt therapist was to be honest about his experiences moment by moment of the session. So he would sometimes say to me, 'Wow, when you said that I felt really sad. I felt really worried that I had said too much. Right now, I feel like I'm speaking too much.' He would often just say exactly what he was feeling, which I felt was really real. It modelled how I could be real back.

At this time, the therapist's self-disclosure generated a sense of genuine connection with the client and served as a model of how to relate on a deeper, emotionally real

level. The high levels of authenticity in this type of self-disclosure involve an attunement and responsiveness to the client's subjective experience and may lead to the promotion of mutuality and increased self-empathy. It communicates to the clients that their thoughts, feelings, and behaviours matter to the therapist and are given serious attention.

Hill and O'Brien (1999) refer to these here-and-now reactions to what is occurring in therapy as 'immediacy' and argue its greater intensity over non-immediate disclosures. Such interventions expose interactional processes occurring in the client's life and re-enacted in the therapist-client dyad with greater clarity (Knox & Hill, 2004). Although sparse, empirical research on disclosure of immediacy suggests its therapeutic usefulness (Rhodes et al., 1994). Research investigating the broader concept of therapist self-disclosure has shown it to be a very potent therapeutic intervention, when used judiciously (Capobianco & Farber, 2005; Knox & Hill, 2004; Knox, Hess, Petersen, Hill, 1997; Hill, 2004). In line with previous findings, the current research has shown that benefits of the therapists' self-disclosure include facilitation of client insight, intensification of affect, and the experience of therapists as more real and human. As discussed by Hill and Knox (2009) such experiences, had a reassuring and normalizing effect on the clients, lead to greater openness and honesty, and inadvertently strengthened therapeutic relationships.

In some instances, the therapist's self-disclosures were experienced as generating a powerful learning experience for the client:

He disclosed a personal story about how he had a speech impediment throughout university and growing up. At first I thought where is this going? It was quite a long story, but it was also very endearing because he still had a speech impediment partially. I was intrigued and he sort of said that as an example to himself ... of how one could live with their fears, with their self-doubt and still do what brought them joy in life, still commit to taking action to do the things that we value. And then I think he used my example, which was anxiety or social phobias, that .... you can live with all of these symptoms. You don't have to wait until these symptoms are cleared out before you can then go out into the world and be a successful human being ... they can co-exist basically. I can take my anxiety along with me wherever I go and still achieve my goals while having this relationship with anxiety. And his example was having this relationship with the speech impediment, learning to be honest and upfront about it, so that was a learning for me of, not trying to get rid of the symptoms basically, but rather working with them and still having the life that you want.

This account offers a unique insight into the process of how the therapist's self-disclosures instigated deep reflection and insight for the client. Ultimately, this form



of self-disclosure served as a mixture of experiential and vicarious learning. Such self-disclosures were also experienced as empowering, in that they gave the client strength to persevere in the face of difficulties. Others similarly spoke about the helpfulness of the therapist in linking the client's experience with their own, but again with the consideration of frequency and timing: "that was done selectively, but when it was done, it was done at times that helped"; and "I felt that her response came as much from her position as a mother in a similar social position to me, as it did from her position as a therapist. This was a very powerful moment in our therapeutic relationship". The value of such experiences is described in the following statement: "I was able to consider another point of view and also compare myself, my own experiences to that [of the therapist] in a helpful manner. It allowed me to reframe what I was going through and what I was thinking and experiencing".

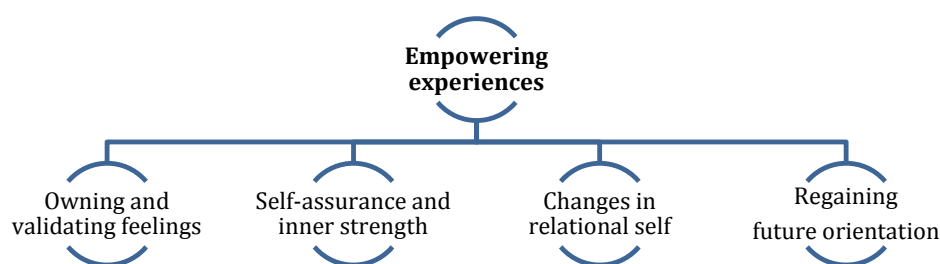
Participants indicated that the therapists' self-disclosures led to positive change, in that, they strengthened realness in the relationship, had an empowering effect, and often provided new contexts for learning. However, as indicated by the participants, the therapists' self-disclosures needed to be thoughtfully shared, often with great sensitivity, and special attention to timing. Effectiveness did not rest on the content, as much as it did on the moment of its application. This emphasizes the need to study why such responses may have been effective at one moment, but unnecessary, intrusive, or premature at another. Therefore, therapists need to be mindful that timing is all-important, because clients may need, at that moment, to have a completely different experience in the therapy with the therapist.

Analysis of this data indicates that deliberate self-disclosure, when used cautiously may contribute to the therapeutic dialogue. As illustrated above, and in line with other studies, self-disclosure on the part of the therapist can take variant forms – answering questions (Jacobs, 1999), revealing personal emotions of the therapist (Bollas, 1987; Marcus, 1997), dealing with real personal factors in the therapist's life (Meissner, 2002; Pizer, 1997), or expressing countertransferential reactions (Aron, 1996). The analysis of the data charts a course between the therapists' unconstrained self-disclosure and absolute anonymity, which as Meissner pointed out, will inevitably foster misalliance. Based on the data, a tentative set of guiding principles for self-disclosure can be established. The main qualities of helpful self-disclosure were centred on the following principles: the right timing, contextual relevance, and the right amount of information, all of which require

mindful evaluation in the context of three ever present components of the client-therapist dyad: the therapeutic alliance, transference, and the real relationship. These findings indicate that the decision what, when, and how to self-disclose, should be guided by careful evaluation of what, at any given point, could contribute to the therapeutic process and the client's therapeutic benefit. As Jacobs (1999) puts it, "each instance of self-disclosure must be evaluated on its own terms in the light of the clinical situation in which it occurs and its effect on the process" (p. 159).

### **Empowering Experiences**

There were numerous moments of significance that resulted in a sense of empowerment. Participants often associated these moments with an experience of self-reclaiming, which generated hope for the future. In essence, these experiences promoted client transition from the stage of demoralization into a new sense of re-moralization.



*Figure 22.* Empowering Experiences.

**Owning and validating feelings.** Participants recognized empowering experiences as deriving from the process in which their feelings were experienced, validated, and subsequently re-integrated into their personality structure. This is well expressed in the following passage:

The main thing that stood out for me was that all feelings are valid .... I suddenly realized that I could get angry and I could be sad and it was totally valid, that sometimes you were going to feel like that .... I realized that I don't have to pretend that I can cope with my world falling apart and not show any reaction.

Participants spoke about the significance of this process and how it allowed reaching the state of compassion, understanding, and forgiveness: "because, if you can have the same compassion for yourself as you have for other people .... I think with understanding comes forgiveness. You can forgive anything if you understand it ....

you have to forgive others to forgive yourself”. Another example illustrated a dramatic progression from the state of feelings being disowned to the state of feelings being re-integrated. As pointed out, this transition took considerable time stretching over a three-year period:

He said, ‘You are walking around the park and there is a kid on a swing and as you get closer the kid is crying. You know, she is five or six and she is crying. And, you know, she has no mother around. What are you going to do?’ And I thought, ‘Pick her up and hold her and comfort her’ and then he said, ‘Go on a little bit further and it is the same scenario but the kid on the swing is you.’ Now, at the beginning of therapy my thing to him was, ‘I want to just slap the little fucker!’ ... because that is how much I was so disconnected from me and the child that needed that ... but, we do the same thing now, and with her on the swing and of course I will pick her up and I will hold her and I will comfort her until she feels better. And that has happened over three years.

The integration of disowned feelings was only part of the process. Over time, this client developed an ability to consciously acknowledge her vulnerable, infantile parts and then to internalize them, along with developing the capacity to take care of, or ‘parent’ those parts of self. For this function to develop in the client, first it would have to be recognized and maintained by the therapist. Within the self-psychology literature, this process is thought of as recognition – the form of relatedness, in which the therapist provides validation of the disowned essential features of the client’s personhood (Meares & Graham, 2008). The therapist’s act of recognition, in going beyond representation into the experience of giving a value to the essential elements of self, paves the way for the client to recognize and reintegrate those previously disowned aspect of self (Meares & Graham, 2008).

In some cases, for the disowned feelings to be recognized and validated, the therapist needed to take a more active stance. Often, absence of certain feelings or their minimization needed to be brought to the client’s attention, typically in a repetitive manner:

I had been minimizing the impact of events from my past and when the therapist was highlighting them as significant, it perhaps had the impact of giving me the ability to step outside of myself and see more objectively. If I was watching someone else, I would have said, ‘yes, those events were really significant’ and for myself I had been minimizing them. So I do think there was a particular point where I could see that perspective that those events were actually really significant personally and did have a really big impact for me. So that was probably a really significant time of change ... and that probably happened on several occasions. It was probably more of a cumulative thing.

Another participant described the instance where his therapist actively enquired and explored the broader spectrum of affect:

She would say, 'Have there been times when you allow yourself to be depressed?' 'Why would I do that?' She said, 'Why not?' And I said, 'Yeah, I do, only when I sit down and when I'm listening to music or I'm writing. I just let it be.' And she said, 'Do you get any of that now?' I said, 'No, not really.' She said, 'Can you make time to be depressed now?' So I thought that was interesting because sometimes the more we try to stave it off, the more it bites us back .... I really felt a lot better about myself in that sense.

Helping the client understand their early emotional experiences and placing them within the appropriate context promoted the process of affect validation and integration:

Her explaining that 'You are the child' and how did I bring up my kids, that I did it differently, again looking at putting the responsibility back on the parent, not you taking it on as the child. It was very helpful that 'that what happened wasn't necessarily your fault, because you were the child and they were the parent'.

Psychotherapy research indicates that change-promoting significant events are frequently affect oriented, with experiences of reassurance, feeling understood, and new 'felt' understanding of difficult feelings (Elliott, 1985; Elliott et al., 1994; Rees et al., 2001; Timulak, 2010). For instance, Elliott and colleagues found that significant moments in psychodynamic therapy involved a new painful awareness. Another study, investigating moments of insight, showed that illumination of the relationship between the symptoms and the pain that underlies it brings to awareness new understandings for the client (Hardy et al., 1998). This process of allowing into awareness difficult and painful feelings, supported by only partial or vague awareness of the specific event, memory, or experience over time generates positive change (Greenberg & Safran, 1987).

**Self-assurance and inner strength.** Participants typically recognized the experience of self-assurance and inner strength as therapeutically significant and highly empowering. This experience was often characterized by a greater sense of stability, security, assertiveness, and confidence; for example: "I have felt empowered being able to take on an emotional problem, whereas before I would let it go"; and "I knew which directions I wanted to go and how I wanted to be treated and how I also wanted to live my life". The inner strength manifested itself in the growing ability to accept one's own vulnerabilities and the need for help; these realizations however, commonly came in the later stages of therapy.

The experience of self-assurance and inner strength was also recognized on the bodily level:

I have no idea what we had been talking about in therapy, but I just remember as I was walking along the street, I felt ... just really good ... sort of confident, self-assured. ... I felt really slim in my clothes. In some ways it was almost like, 'Oh my clothes feel a bit baggy on me and I feel really slim.' I do remember that sense one time, but I have no idea what we had been talking about. ... there were times when I would leave and there would be real sense of strength.

For this participant, it was a 'felt experience' that stood out as an indicator of change. Here, the primary mode of consolidation of insight was via bodily perception, which could also be a symbolic expression of the process of shedding what was no longer needed. Another example of a 'felt experience' of inner strength arose from deep self-acceptance. This is also an illustration of the process of individuation, where the client's capacity to define oneself in relation to others marked the moment of self- differentiation:

I was very empowered and very big, but, able to just stand up tall and be big and be me and go, 'Well, this is who I am. If you don't want me, that's fine' but not particularly being worried about what they thought about me, and I suppose that was something that she [the therapist] left me with as well is ... being cantered and balanced internally, which means that nobody else can ever touch me because it is mine.

She further explained how, over time, this process was experienced and internalized:

It was a spark, it was a little bit, and so each time I would come out with a bit more and then it would last a little bit longer and then it would sort of dissipate, and then it would build again the next time and go a bit further and then it would sort of completely extinguish itself, as such, and ... at the end there was this amazing feeling for at least a week where it was just, I could take anything on.

Others also acknowledged that a sense of confidence and inner strength often developed as a result of the therapeutic relationship, that provided the client with sense of deep acceptance:

I had an intellectual understanding of myself as a reasonable person and a good friend and a decent mother, but it wasn't very psychologically grounded, so I found my therapist's ... affirmations of my parenting ... my position as a friend, all of those sorts of things, I did feel much more positively about my psychological competence.

And since then there have been times when I was thinking, 'Oh bugger!' But the fact that I have actually felt that so intensely before means that it has given me something that I have never felt before, that unconditional acceptance and that empowerment, and that okayness to be just as you are, warts and all. ... having felt that once means that I know that it is possible, and that it isn't something that will be that strong all the time, but it is a bit of a wave, and it is about perhaps having it a bit milder rather than a big whoosh for some time. The waves aren't quite as big, a bit more steady, and I feel that, over time, I have actually distinguished that I have had lots of hard times in between, but there is still that part that I can come back to.

These participants emphasized how the ‘core sense of self’ with inner strength, once established, was sustained internally and could be returned to at times of difficulty. In some cases, acceptance was promoted in more direct ways, through a direct permission giving or specific suggestion: “I was obviously lacking in confidence in taking a position and she just sort of said, ‘Look ... why don’t you just ...?’ and it was said with such a lightness, which I just loved, I think that was very important to me”.

Having developed a sense of internal stability was for some participants one of the major signs of improvement; its effects are illustrated in the following excerpt:

There is a sense of empowerment, in that things happen and I am more grounded and it doesn’t throw me and it doesn’t bother me and there are a whole lot of changes that went on around here and I just sailed through it .... interactions with people where I have kind of asserted myself and had to address things but it hasn’t really bothered me. I haven’t felt particularly anxious or concerned or worried so much about their reaction. I have just done it. That being more grounded and just noticing that I perhaps react a bit better to things than I used to.

This material is indicative of a trajectory, where greater self-acceptance leads to an increased capacity to stand up for oneself and subsequently to feel more empowered.

There were two major components to the development and the experience of assurance and inner strength. The first was more cognitive and intellectual: “acknowledging how I made choices that I like, acknowledging that I took action that was what I chose, and not feeling like I was a victim to any other forces, be those internal or external”. The second was the other visceral and recognized on the bodily level: “recognition that I can tell inside me what is right for me, that was really empowering, rather than doing what I think I should do or what other people want me to do”. This process of greater empowerment and autonomy was also characterized by various realizations becoming conscious:

All of the insights I have had so far were empowering, just because they kind of tweaked a realization in me. I felt that I had more control after making them conscious; these patterns that were in me became conscious. So I felt empowered to be able to choose rather, than just have them operate.

Similar processes were reported by McElvaney and Timulak (2013) in their exploratory study on clients’ experiences of therapy in a primary care setting. Here, participants who reported ‘good outcomes’ were experiencing ‘heightened awareness of problematic functioning’ and ‘mastery of problematic experience’ which generated greater reliance on their own sense of agency.

**Changes in the relational self.** One common outcome of therapy often has to do with changes in relating to self and others. For participants, the most frequently recognized sign of empowerment was a perceived positive change in the ways they related to others. One of the main relational changes reported by participants included newly acquired levels of assertiveness. Participants' typically made the following changes: they were able to say 'no' without having to appease others; they began recognizing unhelpful relational patterns (e.g. trying to be all things to all people); and developing insight as to problematic aspects of their ways of relating to others. Building on that, they often began paying more attention to their own needs and seeing them as equally significant to the needs of others. All of these changes required a reshaping of personal boundaries; this is well expressed in the following passages:

I deal with things slightly differently, in that maybe before I tried to be everything to everyone, and now I have changed in that I know my limits and I won't let outside forces overwhelm me. I have learnt how to draw the line, so that my life is easy and bearable.

And a lot of boundary stuff has changed for me. I am much more aware of that and much better at keeping those things in place. Rather than giving too much to people or always being available or doing things perhaps I didn't want to do, and that has really spilled into work as well ... learning to keep much clearer boundaries with clients ... it has been a huge thing in my life.

Another commonly recognized dimension of change was an improvement in personal relationships; participants began recognizing their own strengths in the relational context: "the change in the relationship with my husband is empowering because I become more present"; their perceptions and beliefs about others altered; their emotional reactivity subsided, and interpersonal openness increased. Therapy enabled some participants to acknowledge and appreciate relationships in their lives. This often decreased a sense of isolation and an increased sense of community: "I got a sense of belonging ... a sense of warmth". Acquiring a new, more assertive ways of interacting with others lead to improvement in personal relationships. These strategies were recognized as being empowering for the participants without having disempowering effect on others. An example of this was about giving oneself time to think about what one was prepared to do, instead of directly responding to requests. This generated a sense of control over feeling and reactions. Learning to better manage own feelings opened new ways of perceiving others; for example, someone who used to be very sensitive to any signs of rejection in social context noticed a

decrease in the frequency of these occurrences. This participant explained that her understanding, that others are not always very sensitive or attuned, enabled her to start reacting differently in these situations. Here, development of a new insight into the motivations of other instigated shifts in the interpersonal attributions.

Therapists often assisted clients in recognizing modes of behaviours that perpetuated their predicament; this was one of the first things that began to promote positive change. In addition, this was very liberating to discover that their beliefs and perceptions were often incomplete and that things could be changed. Participants often emphasized the value of being challenged on their discriminatory ways of viewing situations:

She had the ability to remind me that the thing I feared ... was just one thing and that life outside of it existed, and in a way that was empowering because I would forget. I would be behaving as though I was powerless and talking as if I were afraid ... afraid of the task, afraid of my own ability, inability, afraid of even not doing the right thing, afraid of failing all the time, and, I remember realizing 'Oh my gosh, this is just one thing .... It doesn't say who I am' and that was very empowering to realize that.

In some instances the therapist's more direct intervention instigated the change in the client:

Do you want to be treated like that?' And I said, 'No.' He said, 'Well no, you don't want to, so just don't. That is something that you have got to not allow.' And that has really stuck with me, that has helped me change in the way that I interact with some people or deal with some people.

Change in the relational self was commonly expressed in developing greater capacity for empathy towards others, as well as an ability to take another person's perspective: "I am more appreciative and supportive of other people's situations and how they look at things"; "It has helped me look at things from people's perspectives more openly and genuinely"; and "therapy has certainly given me a different perspective on the whys and wherefores. Now I sort of try and look at, why does that annoy me?" The relationship between an increased capacity for empathy and subsequent decrease in social isolation was captured in the following example:

The ability to recognize patterns, the ability to be more accepting of situations or forgiving of others has allowed me to utilize other people as resources better. It sounds awful when I say that, but it has allowed me to accept other's help more easily and so my social supports have been more supporting and better activated.

The processes described here were largely about the struggle in altering the space that existed between self and others. In therapy, clients become aware of the ways they stay in connection with others. For example, some participants became aware of



how they kept others away, or how their ability to look after others gave them one kind of contact – a contact with tremendous amount of control while being deprived of mutuality and connection. It can be argued that changes in the relational self were a manifestation of clients’ development of a clearer psychological definition of themselves. These new discoveries exposed what was not there in the first place. It was not uncommon for participants at that stage to acutely experience the discomfort of what was lacking and a strong desire for it, for example, the discomfort and desire for deeper connections with others. Some of them began questioning their own motivation behind the need to ‘fix things’; they were steadily exploring issues below the surface and confronting their own dependencies and hesitancies.

Participants welcomed such shifts as enablers of the process of retrieving or establishing new close mutual relationships. It is argued here, that changes in the relational self are directly related to the process of embodiment. Fonagy and Target (2007) suggest that in the process of embodiment, the individual’s sense of self extends through connecting with one’s environment, culture, and history. This is a progression from having just the physical experience of being in and part of a world, into having a more complex template of the individualized social world, therefore creating greater possibilities for social experiences in an interactive process of socio-cognitive growth (Fonagy & Target). Thus, as described here, changes in the relational self are on the vector of embodiment manifested in the expansion of self into the social context.

**Regaining future orientation.** Some participants recognized the moments in which they began generating hope for the future as empowering. This was the process of transition from a state of demoralization to re-moralization, which commonly arose from the hopefulness generated at the start of therapy by simply knowing that there was someone who was committed to help: “I was very relieved and excited knowing that there is light at the end of the tunnel and I am going to get better”. In order to undergo a transition from hopelessness to hopefulness – “from a black hole into a bright environment”, some participants required therapists’ more overt manifestation of confidence in positive change. Sometimes, it was the therapist’s active questioning pertaining to the future: ‘What are your dreams, your goals? What do you hope to do, hope to be?’ that made the client feel more empowered and hopeful about the future. These future oriented explorations helped

clients realize that they could change how they felt, that they could make a difference to their own situation.

The process of regaining hope for the future occurred with greater frequency in the later stages of therapy, when presenting problems were better managed. Often, it was the end of therapy that brought a strong realization of change and hopefulness towards the future: “I could see, I thought, ‘Oh, I’ve changed. I’m not sitting here miserable and hoping; the future is all black. I can see that I’m empowered and feeling confident and got some direction in my life’”. For one participant, the most empowering moment in therapy was realizing that it was time for her to leave:

I have paid my account to the receptionist, got in the car and drive off and I am a minute or two down the road and I am just thinking, ‘I don’t ever have to go back and see that therapist again. I don’t owe anything to anyone. I do not have to go. I am free to leave.’... that was probably the most therapeutic thing for me .... it was outside the [therapeutic] space, but.... that was really quite powerful.

For this client empowerment came from an ability to stop therapy upon realizing that it was no longer helpful. This participant added that, based on her personal history, she went into therapy believing that “it is not safe to speak up”, but over time came to the realization that “it was not safe to remain silent”. Hence, in this case, the decision to leave therapy had a very significant empowering meaning.

Hope for the future was installed in one participant when the therapist offered an explanation of a traumatic life event that challenged her excessive sense of guilt and responsibility: “[the therapist said] what if you just thought that perhaps some things just run their course. And that for me was a bit of a light bulb moment .... It gave me a sense of freedom that there was nothing I could have done that would have made much difference”. This realization enabled the client to rid herself of all consuming guilt and excessive sense of control over the events in her life; in doing so, she freed some space in herself to contemplate future in less restricted ways.

The current findings, similar to previous research (e.g., Levitt, Butler, & Hill, 2006; Manthei, 2007; Watson, & Rennie, 1994), suggest that the relational aspects of significant events are of outmost value to the clients. They provide the necessary platform for change-inducing experiences to take shape. This analysis shows that events nominated as change-generating grew out of a very close and deep therapeutic relationship. Despite different treatment modalities, participants consistently referred to the same events as having significant transformational impact. The main area of transformation included the experience of embodiment.

These were changes mutually generated on the bodily, affective, and cognitive level leading to a deeper experience of self. Emphasis was also placed on the transition from a state, in which parts of self were disowned, into a greater feeling of wholeness and completeness. Participants also developed a new future orientation as a result of having empowering self-reclaiming experiences. Overall, the accumulative impact of these experiences facilitated transition from the initial state of demoralization into a hopeful state of re-moralization.

One of the findings, that seem particularly vital for therapists, is that the moments viewed by participants as significant were experienced in some ways as being new and unfamiliar. These experiences generated in therapy needed to be felt as genuinely new so they were not simply transposed into already known and familiar schemas, but instead became an opportunity for development and growth. Clients are often stuck in the repetition of certain patterns; this reflects inflexibility of mental processes, which are not receptive to new and original ways of thinking, feeling, and behaving. It is suggested, that in order to break these patterns and for the client to be able to respond in an enlivened way, the therapist needs to be open to new possibilities. This state of mind allows for previously unfelt, unthought-of, and unknown material to emerge in the therapeutic dyad. Orbach (2005) expressed this notion in the following statement: “therapy is truly alive when both patient and analyst are understanding anew” (p. 68). This, in turn reflects Bion’s (1963) dictum that the therapist needs to enter each session in a state of ‘no memory and desire’, because only then new understandings can develop.

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## CHAPTER Eight

### General Discussion

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Although a substantial body of research identifies the client as one of the most significant factors in therapy outcome, very little is known about the client's subjective experience of the psychotherapy process and the mechanisms that are deemed most helpful in facilitating change (Bohart & Tallman, 1999; Duncan et al., 2010; Norcross, 2002). In spite of a substantial number of theories on change in psychotherapy, there is a conspicuous absence of theory based upon clients' subjective experience and understanding of therapy. This underrepresentation of the client perspective is concerning, particularly in light of considerable evidence about differences between clients and therapists regarding core aspects that are central to positive treatment outcome (Bachelor & Salame, 2000; Horvath, 2001; Horvath & Bedi, 2002). In addition, meta-analytic studies confirm that it is the client's perspective that provides a better predictor of positive outcome (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). The current study aimed to expand existing research (e.g., Elliott, 2008; Kazdin, 2005; Manthei, 2007) on client-identified factors and processes relevant to positive treatment outcome by seeking to outline clients' understanding on how change occurs in psychotherapy.

The core research question in this study was: *How does therapeutic change occur from the client's perspective and what factors account for that change?* The specific objectives of this research have been exploratory in nature. The central purpose was to uncover clients' views on the factors that facilitate change in therapy, including their own contributions to therapeutic change, and the therapist's role in bringing about and maintaining therapeutic change. In addition, this study investigated clients' informal theories of problem formation and problem resolution in relation to therapeutic change. It also aimed to articulate a therapeutic change model, based on client discourse on the nature of change. In meeting the above objectives, key findings will be first summarized and then mapped onto selected models of change. Then they will be applied to a heuristic client-based model of change. Finally, a range of implications for the field will be discussed and possible future research directions will be outlined.

## Summary of Key Findings

This section will provide a brief summary of the key findings within each domain discussed in detail in the previous chapters.

### Experience of Change.

#### Participants recognized the importance of:

- Change experienced as: *“continuous, gradual, subtle progression”; “gradual softening and shaping of things”; “I haven’t got a clear sense of stages... It is more fluid”; “It is probably a slightly messier structure than a staged notion”*
- The provision of a safe space and time for intense focus on self: *“Never crowded, rushed, or pressured”*
- Emotional nurturance as growth-promoting: *“It was like that infant attachment, which is something that you could take with you and tap back into at times”*
- Silence as integrative and deepening factor: *“Some silence and some space...got me into further directions”*
- Therapeutic presence – healing potency of being with and being witnessed by the therapist: *“When someone is watching you and just being with you, there is something healing about this”*
- Discovering previously unknown aspects of self: *“Finding out so much more along the way was very important”*

The examination of clients’ experiences provided a direct window into what can facilitate the process of change, which in turn, may lead to a better understanding and, ultimately, the improvement of psychotherapy. Clients typically experienced change as a continuum, a gradual process that unfolds over time. They placed emphasis on an ongoing development of new structures, as opposed to having clearly defined moments of transition. There was a consensus amongst clients on the lack of distinct stages, leading to specific changes. Change was a nonlinear process, which required the sustenance of an environment conducive to deeper psychological work. In addition to the ongoing and cumulative nature of change, emphasis was placed on the readiness for change. The right timing of an intervention was seen as a necessary determinant for an acceleration and achievement of optimal psychological growth.

Most importantly, the results indicated that strong relational mechanisms were implicated in psychological change. In particular, they suggest that change was a deeply relational process, in which the therapists’ full emotional presence

facilitated clients' deeper self-examination. Clients found a sense of being deeply cared for, in the context of a safe and stable therapeutic relationship, that had an emotionally reparative function. In these instances, therapy went beyond symptom reduction and offered developmentally corrective experiences.

Clients also stressed the importance of the provision of a safe psychological space as a necessary condition to process material and raise awareness. In order for the space to become psychologically safe and therapeutically viable, it needed to be experienced as a place where they could let go of some degree of control and began working on a deeper psychological level. In order for this to be possible, they needed to perceive the therapist as skilled and competent in providing a necessary level of safety. The second critical composite of safe psychological space was silence and time, described here as a particular form of attention, in which psychic activity is withdrawn from the outside and directed inwards. While more subtle, this form of being with the client appeared to facilitate deeper self-exploration and introspection. An interesting finding was that clients who reported being able to experience states of the deepest quietude have done so because they felt the therapist was capable of enduring silence. The final constituent of a safe psychological space was therapeutic presence. This was frequently referred to as the capacity to be with the clients at their most vulnerable and able to bear the intensity of the process. It was typically evoked by experiencing the therapist as truly engaged and interested in the client, and as a continuous and reliable presence in the client's life. There were also less observable aspects that made the therapist's presence therapeutic; these included: caring for the client, trusting in the process, remaining neutral, and facilitating introspection.

Another facet central to the process of change was the experience of greater cohesion and continuity of self. Clients described this as a felt experience, where different features of personality were experienced as facets of a single, well-integrated structure. This, in turn, was reflected in a stable, positively valued, and congruent set of qualities, ideas, and values. In this process, clients moved from the experience in which parts of the self were compartmentalized or disowned, to a state where they become assimilated. This integration was also accompanied by greater self-awareness and development of new meanings. This state often led to discovery of previously unrealized and unknown aspects of self. Overall, clients described change as a relational process, experienced as a dynamic and nonlinear trajectory,

which while confronting, emotionally painful, and very challenging, resulted in personal growth and sense of liberation.

### **Stages of Change.**

**Participants experienced stages of change in the following way:**

- Beginning phase as very turbulent, challenging, yet relieving: *"The place of chaos and turmoil"; "That sense of relief in the beginning...that she was going to help me was wonderful. That I wasn't on my own was very important"*
- Middle phase as transition into a deeper psychological level: *"Dealing with the core self"; "Moving from surface to underlying issues"*
- End phase as consolidating and promoting greater authenticity and integration: *"Finally complete and stronger...full circle"; "Bringing together the past and the present, the intellectual and the emotional"*

Findings from the current study revealed that change is experienced as a fluid and gradual process, lacking distinctive moments of transition. However, stage-like characteristics were discerned, when change was explored within the context of the beginning, middle, and end stages of therapy. There were three phases of change described by clients, irrespective of presenting issues, length of treatment or treatment modality. The first phase was characterised by a sense of disorganization and detachment. Here, common experiences included a sense of internal and external chaos, entrapment, and lack of direction. Clients frequently felt lost and devoid of psychological resources to manage difficulties. This commonly resulted in feelings of depression and greater distress. The need to give expression to painful feelings in the presence of the therapist was particularly important. The establishment of trust was central to this stage, involving a complex and often lengthy process of assessing the therapist's competence and the safety of the relationship.

Movement from surface level issues into deeper layers of psychological distress marked the middle phase. Clients found that addressing deeper intransigent issues first required overcoming the more immediate difficulties in their lives. In other words, there was a need for external stability, in order to begin explorations of more complex and challenging issues. Fluctuation between progress and regression and the difficulty in maintaining sufficient levels of motivation and hope was characteristic of this stage. However, towards the end of this phase, clients reported a reduction in symptoms, along with greater awareness of their personality structure.

The end phase of therapy was characterised by clients' experience of greater authenticity and integration. A sense of self-sufficiency and independence began to emerge, presenting issues were resolved to a greater extent, and consolidation of newly acquired insights and new ways of addressing problems was underway. The end phase was also characterised by experiencing the therapeutic relationship as more real and reciprocal.

### **Problem Formation and Resolution.**

#### **Participants reported:**

- Surface understanding of problem formation and resolution prior to entering therapy: *"On the surface level I might have had an idea of what was going to help and I might have had some theoretical understanding of what might have helped, but I don't think that I really knew"*
- Explicit theory as not helpful in generating change: *"I felt like I had really good theories but that they didn't make a difference. I might understand why I felt the way I did, but being able to do something about it is kind of the challenge"*
- Allegiance to treatment model meant: *"The idea of what I thought would be helpful meant that congruent therapy suggestions were easier to act upon and I was more instantly motivated to work through them"*
- Client agency derived from having sense of discovery and application of learning from therapy into their life: *"discovering it for oneself"*

Clients typically reported having limited understanding of the origins of their problems and ways of addressing them, irrespective of whether they were psychologists. Typically, they expressed some degree of intellectual understanding, along with hope that therapy would elucidate causes and solutions to the problem. Initial explicit theories of problem formation and resolution usually underwent modification over the course of therapy. Clients also recognized that having an understanding of problem formation and resolution was insufficient in generating change. All clients, however, considered therapy a necessary prerequisite for change and found it conducive to resolving their problems.

Clients typically expressed some preference for the type of therapy as well as therapist and therapeutic environment. Therapist-participants were more confident in describing the type of treatment they would likely benefit from, whereas non-therapist participants relied more on an implicit and intuitive understanding of what could help them. Both groups showed preferences for therapists, who either shared their worldview or were willing to explore and subsequently incorporate the client's perspective into the treatment. A conducive therapeutic environment was described



as one that provided containment and continuity. This was related to an open-ended form of treatment, which enabled clients to gradually develop their own answers. Findings indicated that, in order to achieve an optimal treatment outcome, these three factors needed to be present to a satisfying degree. Having an intellectual allegiance and curiosity in relation to a particular therapeutic framework, when complemented by a preferred therapist and a conducive therapeutic environment, led to positive changes.

Findings also showed that clients were highly argentic in the co-creation of therapy processes. This manifested itself in an ongoing evaluation of the therapist's skills and attitudes in determining when, what, and how much to disclose. Clients did not simply volunteer information, but instead, actively tested the therapeutic situation for signs favourable to self-disclosure. This went beyond just needing to 'feel safe' with the therapist. The therapist's ability and willingness to receive sensitive information, to tolerate, understand, and be with the client were tested. Another source of agency came from clients' ability to apply learnings from therapy in their life, which for client-psychologists extended into applications within the professional domain.

### **Helpful Factors.**

#### **Participants recognized as therapeutically valuable the following:**

- Stable therapeutic 'frame' as a pre-requisite to deeper therapeutic work: *"he was very consistent", "she was always punctual", "the ability to be able to contact her if I needed to was important, but also her boundaries around that"*
- Experiencing therapist as developmental object, a trusted and receptive figure, a 'sound mirror' representing the client's self to himself: *"It was accurate reflections of my contributions"; "on the same wavelength, she was there, there was a certain ebb and flow"*
- Experience of being emotionally contained: *"I knew she was there...but I knew she wasn't being pulled under by me and that she was able to hold the fort for us both"*
- Experience of being in a real and deep relationship: *"much more important to me than a frame of reference, is the relationship"; "understanding my experience..., that is as real as I can imagine"*
- Experiencing previously unfelt affect (turning unfelt emotions into felt ones): *"I didn't feel that intensity until in the four walls and with another person"*

Helpful factors included the qualities of the therapist and the therapeutic relationship characterized by acceptance, support, and non-judgementalness. Clients

placed an emphasis on the qualities of the therapeutic frame; safety of the therapeutic space, clear boundaries, and the therapist's predictability and availability were all-important. A sense of continuity and consistency was a necessary pre-requisite to deeper therapeutic work, in that it allowed clients to emotionally regress and work through powerful affects, without fear of impingement or judgment. This sense of safety, most likely, enabled the clients' to begin experiencing the therapist as providing developmental functions. This was achieved through the formation of a solid attachment, followed by the internalization of the therapist.

Attunement played a critical role in the development of secure attachment. Amongst essential qualities of the attuned therapist were: the ability to connect and respond to the subtleties within dyadic communication, emotional presence, attentiveness conveyed by body language, inter and intra-personal sensitivity, emotional mirroring, and synchrony. In addition, the therapist's ability to function as a container, translator, and modifier of unprocessed feelings were recognized as extremely important. Clients consistently emphasized that authentic personal engagement, where they felt deeply understood was essential for them to engage and remain in treatment. They valued it over any specific therapeutic technique or theoretical frame of reference. Instead, therapist competency, professional skills, and knowledge were seen as valuable, only when present in the context of warmth, realness, perceptivity and flexibility. Finally, clients found helpful the therapist's assistance in: (1) affect regulation, in which emotional content undergoes elucidation, processing, and transformation, and (2) integration, in which past events are reactivated and reintegrated with current material, which in turn lead to greater cohesion and continuity of self.

### **Hindering Factors.**

#### **Participants recognized as unhelpful:**

- Therapist rigid conceptualizations and rigid treatment approach: *"I felt like I was being dealt with by a practitioner with a bag of tricks"*
- Therapist exertion of too much or too little control: *"firm boundaries are important, but there is some delicacy around being firm and not being controlling"; "I felt lost in the directions I was travelling...I would have preferred some more guidance from the therapist"*
- Therapist misattunement: *"different wavelength"; "trying too hard"; "...it damaged the bond in some ways, because it would show that I was being misunderstood"*
- Therapist inability to address issues arising at the termination phase: *"the end of therapy wasn't good. It was a truncated end, abruptly truncated end"*

Clients identified a number of therapist-related factors that were hindering to the therapeutic process. Apart from inaccurate and poorly timed suggestions and interpretations, significant importance was ascribed to excessive or limited structure. This was typically manifested in either the therapist's inflexibility or rigid adhesion to rules or, on the other hand, their inability to provide a sufficient structure. A routinized approach to treatment was particularly detrimental to clients. This was evidenced in excessive reliance on diagnostic criteria and treatment preconceptions, often mechanically applied to the clients' complaints. Likewise, premature establishment of goals done without consultation with the client was experienced as detrimental. Clients strongly opposed being offered immediate ways of addressing their difficulties, as it made them feel depersonalized, objectified, and misunderstood or understood in only a very superficial way.

Clients found that a very rigid structure imposed prematurely often foreclosed the emergence of deeper issues. Similarly, insufficient structure and lack of direction led to an overall sense of instability and lack of safety. Above all, clients found fear of being negatively evaluated by the therapist extremely detrimental to the therapeutic process. This sensitivity to being judged was particularly strong in the early stages of treatment. In the later stages, clients viewed therapist's limited attunement as a major hindering factor, whereas in the final stages it was the therapist's unskilled way of managing termination that was perceived as particularly problematic. Clients emphasized that premature, incomplete, and insufficiently handled terminations had potential to negatively effect the overall experience of therapy.

### **Significant Moments.**

**Participants acknowledged as significant the following:**

- Moments of insight: *"turning on a light bulb"; "moments of sudden revelation"; "It was like when you put the last piece on the jigsaw puzzle"*
- Transformational moments: *"physiological rush as well as a thought process of very clear connections between concepts"*
- Moments of deeply felt emotions: *"I felt like she had tapped right in to my inner thoughts and inner everything"; "It felt like someone has touched my soul as no one has ever before"*
- Moments of honesty and realness: *"both people are sharing the same reality"; "sitting with mutual vulnerability and imperfection"*
- Therapist's emotional self-disclosure: *"one of the most profound moments was when she was saying something about me and you could tell it really came from the heart because,..., her eyes welled up"*

Moments recognized by clients as significant were typically perceived as having transformational value. They were often experienced as sudden realizations, accompanied by a sense of euphoria or enlightenment. Apart from generating hope, these moments were also seen as an indispensable aspect of the learning process. Despite their significance, there was no consensus amongst clients as to how these moments came about. The precipitating factors most frequently mentioned were a sense of deeper relaxation, provision of silence and space, and the therapist's ability to see the 'bigger picture' and recognize the underlying meaning.

Descriptions provided by clients about what happens during these moments strongly indicate that insight which is transformative activates a three-level experience including: 'felt' or bodily experiences; real and deep emotional responses and cognitive clarification. Clients emphasized the 'bodily felt' level experience over its cognitive counterpart. Their retrospective recalls showed that those 'aha' moments were steeped in somatosensory experiences. There also appeared to be a distinct trajectory for change-inducing insight as beginning with the activation of the bodily/felt, followed by the affective/emotional, and finally the cognitive/intellectual level.

In stressing the importance of affect in psychological growth, clients' acknowledged the transformational value of deeply felt emotions. For instance, empowering experiences often derived from the process in which feelings were experienced, validated, and subsequently re-integrated into the personality structure. It was the therapist's understanding presence and ability to reflect this to the client that transformed this process into a 'real' and 'alive' experience of continued growth and change-induction.

Therapist realness and honesty, of which one important marker was humour, were found to be highly significant. Therapist self-disclosures were also experienced as moments of transformational value, providing they were timely and thoughtfully shared. Overall, significant moments had a revelatory quality and often came unexpectedly. The unexpectedness seemed to be a critical component of these kinds of experience, pointing to the state of 'not knowing' as an enabler of novelty. The underlying mechanism in all of these experiences included alignment of the cognitive, affective, and bodily level responses, which when repeated over time in the presence of an understanding and reflective therapist, led to change-inducing insights.

## Stage Models of Change

In this section, the study findings, which were obtained without using a pre-determined taxonomy or set of stages of change, will be mapped onto selected models of change. The two models that have been most extensively researched and applied within the psychological treatment of wide array of behaviour problems are: *The Transtheoretical Model of Change* (Prochaska & DiClemente, 1982), and *The Assimilation of Problematic Experience Model* (Stiles, et. al., 1990).

According to the Transtheoretical Model, behavioural change occurs in a series of discrete stages. However, some authors suggest that the proposed stages are not mutually exclusive and that there is no compelling evidence of the sequential movement through discrete stages (e.g., Carey, Purnine, Maisto, & Carey, 1999; Little & Girvin, 2002). Major criticisms of the Transtheoretical Model concern its oversimplification of the nature of change with imposition of artificial categories on continuous processes (Davidson, 1992; Little & Girvin; Sutton, 1996). While researchers are divided as to whether change is best represented as a continuous process or by discrete stages (Prochaska & DiClemente, 1998, p. 39), the current findings support the view that change is more closely aligned with a continuous process, rather than a series of distinct and sequential stages. Experiences described by the participants in the current study do not map onto the stages of change delineated in the Prochaska and DiClemente's model (1998). This may be indicative of the fact that this model lacks a sufficient explanatory power to capture the complexity of the change process in longer-term therapy.

Descriptions provided by the participants in the current study, however, more closely resembled change as conceptualized within the Assimilation of Problematic Experience model (APE) (Brinegar, Salvi, Stiles, & Greenberg, 2006). The APE is a theory that conceptualizes psychotherapeutic change as a developmental process in which problematic experiences are assimilated through establishment of meaningful links. These are referred to as "meaning bridges" (words, images, narratives, theories), which occur between the therapist and the client, as well as internally in the form of interactive voices (Brinegar et al., 2006; Stiles, 2009). According to this theory, assimilation of disconnected internal voices (or aspects of the self) occurs as a result of building semiotic meaning bridges via external and internal stimulation (Dimaggio & Stiles, 2007). The therapeutic process requires connecting them via meaning bridges. The assimilation of problematic experience follows a

developmental progression of eight sequential stages, reflective of the problematic experience of the self: i) warded off/dissociated, ii) unwanted thoughts/active avoidance, iii) vague awareness/emergence, iv) problem statements/clarifications, v) understanding/insight, vi) application/working through, vii) resourcefulness/problem solution, and viii) integration/master (Stiles, Osatuke, Glick, & Mackay, 2004).

The current study identified three broad phases of psychotherapeutic change, which can be mapped onto the eight-stage APE model. The beginning phase of disorganization and detachment, in which dominant experiences are these of chaos and distress, parallel the dissociation and active avoidance of unwanted thoughts in the APE model. The process of unloading feelings and building trust, characteristic of this phase, corresponds to the APE phase of the emergence of a vague sense of awareness, which similarly is facilitated by the emotional expression in the trusted relationship. The middle phase, in which progression from symptomatic to structural change takes place, reflects the APE model stages of problem statements/clarifications, understanding/insight, and application/working through. Finally, the tasks and experiences described in the end phase of consolidation parallel resourcefulness/problem solution, and integration/master of the APE model.

The current findings also map onto stages of the Phase Model of Psychotherapy to some extent (Howard, Lueger, Maling, & Martinovich, [PMP] 1993). The PMP posits sequential improvement in the following phases of change: (1) phase of remoralization, in which alleviation of hopelessness and instilment of optimistic expectations and beliefs leads to enhancement of the client's subjective sense of well-being. Similarly, in the current study the beginning phase concentrates itself with establishing trusted relationship in which feelings of hopelessness, depression, and distress can be reduced; (2) phase of remediation, in which the establishment of a positive therapeutic alliance facilitates mobilization of existing and/or learned coping strategies leading to symptom remission. Likewise, in the current study the middle phase was characterized by symptom reduction and establishment of a deep and solid therapeutic relationship; and (3) phase of rehabilitation, in which modification of maladaptive patterns and establishment of new more adaptive ways of functioning occurs, leading to enhancement of life functioning. Based on the current findings, greater self-sufficiency, authenticity, and independence marked the end phase. Furthermore, analogous to the current study, Perren, Godfrey, and Rowland (2009), in their analysis of participants' accounts of

the counselling process, identified three broad phases: i) beginning, in which participants become engaged and the therapeutic relationship was established, ii) doing the work, in which participants engaged in exploration of internal and external worlds, and iii) ending, in which consolidation of self-knowledge and strategies took place.

Despite some degree of similarity, these models of change do not sufficiently account for the complex processes described by the participants in the current study. This, in part, might stem from the fact that they were originally developed to examine process of change in short-term treatment (e.g., Goldfried, 1991; Heppner & Claiborn, 1989; Highlen & Hill, 1984; Mahoney, 1991; Rice & Greenberg, 1984). Given that the current study concerns itself with processes of change within longer-term therapy, it may be necessary to expand beyond models developed on the basis of short-term treatment. In order to bridge this gap and capture the breadth and depth of psychological experiences described by the participants, selected research findings from the field of psychoanalysis, attachment theory, and neuroscience will be introduced. These research findings may offer conceptual tools to facilitate a more in-depth understanding of the mechanisms of change within longer-term therapy. The next section will discuss the client's model of change generated based on the findings from the current study.

### **The Client's Model of Change**

One of the aims of this study was to generate a model based on the client's experience of change in psychotherapy. While the findings do influence and contribute to a theory of change in a broader sense, the richness and comprehensiveness of the data warrants the formulation of a heuristic model of the client's theory of change. This model provides an exploratory map of some of the emotional and psychological experiences of individuals who have undertaken longer-term therapy. This section will begin with discussion of the characteristics of the three stages of change. After describing these stages, the research findings from the current study will be explored and critically evaluated, utilizing contemporary psychoanalytic framework to illuminate the data.

The research identified several strong elements of shared experience amongst therapists and non-therapists in terms of the process of change. Notably, no stages were readily identified by the participants. Instead, they described change as a continuous process that unfolds gradually over time. They placed emphasis on the

continuous development of new structures, as opposed to having distinct moments of transition in therapy. However, general characteristic features of beginning, middle, and end phases of treatment were distinguished, based on the clients' accounts.

As already discussed in the previous section, the beginning phase was experienced as a state of emotional and physical disequilibrium. It was characterized by emotional turbulence and chaos, along with sense of detachment. In the majority of instances this was accompanied by an intense emotional state of depression and distress. The need for a safe place, where they could begin to articulate feelings, predominated the early stages of treatment. The therapist's facilitative role in the emergence of the narrative was critical here. This therapeutic task has been theorized in psychoanalytic literature as an emotional 'unblocking', that necessitates the symbolization of emotional reactions into feelings and words (Sander, 1995). Although these early emotional experiences were very intense, the depth of 'felt experience' was recognized as a prerequisite for transformational processes within psychological structures. In other words, emotional individuation requires sustaining an ongoing accessibility of affective states, which over time can undergo modulations and consolidations (BCPSG, 2010).

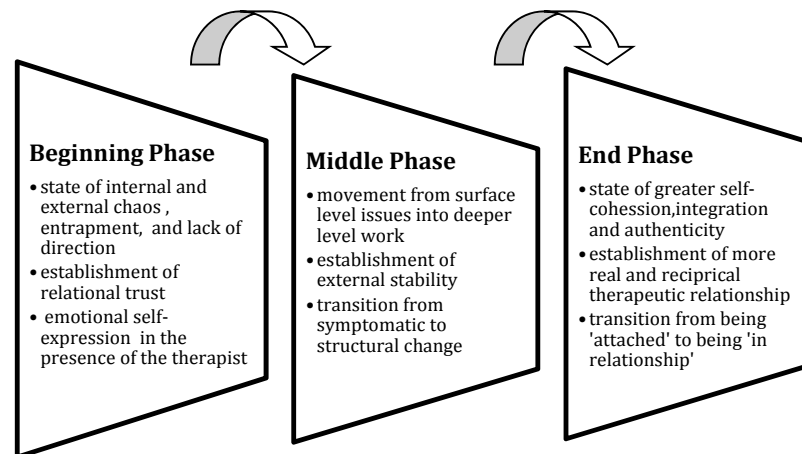
In order to transition into the middle stage of treatment and begin work on deeper psychological levels, participants had to experience life as more settled and feel as though they had sufficient skills to manage day-to-day difficulties. Progression to this stage however, was not linear; participants reported an oscillation between surface and deeper levels. This constant fluctuation activated resistance and a greater need for the therapist's assistance in sustaining their engagement in the therapeutic process. The nature of this process and its intensity required pacing and time for consolidation, along with supportive interventions. In order to progress, participants needed space, time, and emotional support from the therapist.

In the final consolidating stage of therapy a sense of satisfaction, accomplishment, and strengthening predominated. One of the facets of consolidation that gave a more coherent and harmonious experience of self was an increase in self-integration. This was expressed through greater acceptance of different parts of the self, as well as acceptance that difficulties were a part of life. At this stage of therapy participants began experiencing themselves as more complete and at ease with themselves. There was a more mature and realistic outlook on self and the world. Another characteristic of this stage was a transition from being 'attached to', to



being in a 'relation to', both self and others, as a wider perspective on things developed.

Findings indicated that change is generated via multiple mechanisms that can be organized into a two-dimensional model. The first dimension is the relational process underlying therapeutic change. The second dimension encompassed cognitive, behavioural and emotional states experienced by the clients in the beginning, middle, and end phases of treatment. According to this model, change is understood as a relational and dynamic process. Here, the relational engagement between the therapist and the client serves as a catalyst and sustaining force for therapeutic change. In other words, the relational dimension is the canvas on which clients' cognitive, behavioural, and emotional capacities develop. Figure 23 portrays the first dimension of the client's model of change: the phases of change.



*Figure 23.* The Client's Model of Change – first dimension.

In light of findings addressing the relational component of change, the model was further developed to incorporate the dyadic dimension of the client's experience of change. Figure 24 illustrates the proposed connections between these two-dimensions.

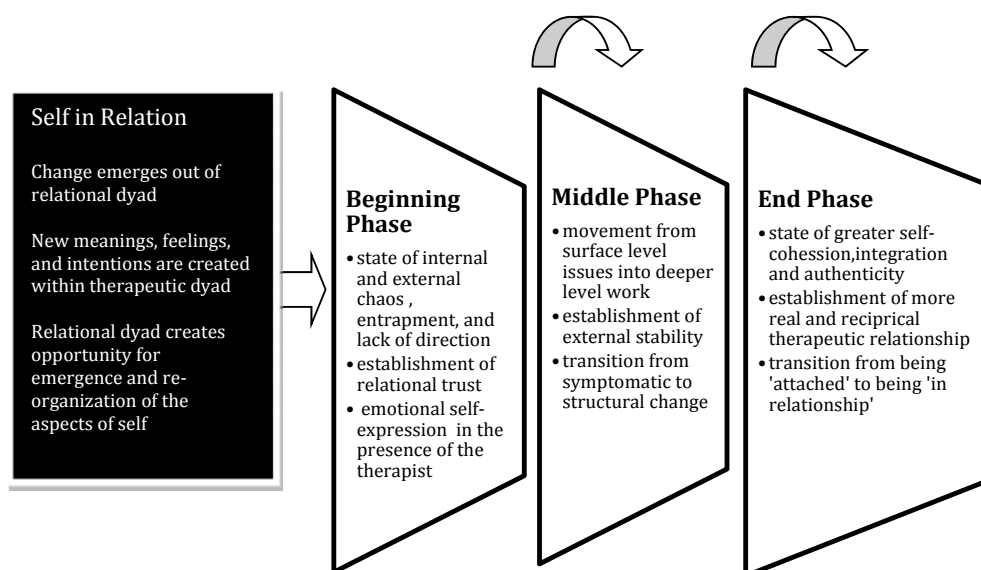


Figure 24. The Client's Model of Change – first and second dimension.

Based on the findings from this exploratory research, it is proposed that the self develops and grows in relationship. Thus, for therapeutic interventions to gain transformative power they need to emerge out of a deep and genuine relational context. Understanding and insight need to go beyond 'intellectual knowing' and become a 'lived experience' within a two-person relational context in order to be internalized. The model stresses the importance of the relational arena, in which interaction between therapist and client allows for emotional content to undergo elucidation, processing, and transformation, leading to greater cohesion and continuity of self. It points to the lack of one universal set of principles that account for change. Instead, change is understood here as being generated via multiple mechanisms, all of which stem from dyadic exchanges between the client and the therapist. The following section will delineate ways in which these therapeutic change processes occur, along with recent evidence from psychoanalysis.

**The client's model of change within contemporary psychoanalytic frameworks.** Contemporary psychoanalytic models are moving toward viewing the relationship between therapist and client as central to therapeutic change (e.g., Beebe & Lachmann, 2005; Cromwell & Panksepp, 2011; Fonagy & Target, 2007; Green, 2003; Schore, 2011; Tronick, 1998; Trevarthen, 2001). Placing greater emphasis on exploring relational processes is consistent with research evidence suggesting

change-promoting factors to be largely located within the therapeutic relationship (Beebe & Lachmann, 2005; Cromwell & Panksepp, 2011; Green; Schore; Tronick, 1998; Trevarthen, 2001). Contemporary psychoanalysis, while placing central importance on the interpersonal and intrapsychic processes, has also begun incorporating findings from neuroscience, developmental, and attachment research. As a result, the validity of a single or universal model of therapeutic change has been questioned. According to Gabbard and Westen (2003), change mechanisms are individualized within each therapeutic dyad: “With the demise of any consensually held notions of ‘standard technique’ has come an increasing flexibility in psychoanalytic practice and a recognition of the inevitability-and value-of the negotiation process that takes place in each analytic dyad” (p. 825).

The Client’s Model of Change proposed here can be conceptualized within the BCPSG (2010) theory of change, a paradigm that unifies psychoanalysis, child development, neuroscience, and attachment theory. This theory presents a radically new way of understanding therapeutic change as it occurs in the therapeutic dyad. The underpinnings lie in mother-infant research, Piagetian psychology, intersubjectivism, and the organizing principles of Dynamic Systems Theory (Bruschweiler-Stern et al., 2010). Explicit, conscious understanding or insight is considered secondary, an addendum to change that originally occurs on the unconscious level of implicit relational knowing (Bruschweiler-Stern et al., 2010). The core concept of “implicit relational knowing” is understood as an unconscious nonverbal knowledge of the intentions, attitudes, and emotions of another person. This knowing is affective, interactive, and cognitive at the same time. It enables individuals to develop ways of being with others, to know how to do things with others (i.e., knowing how to express affection, how to make close relationships) (Bruschweiler-Stern et al., 2010).

The difference between explicit and implicit knowing is comparable to the difference between procedural and declarative knowledge. This is the difference between knowing *how to do* something versus knowing *about* something. Clients often have a great deal of knowledge and understanding of their personal predicament, but still are unable to change. They know ‘about’ their difficulties but do not know ‘how to’ change the pattern. This is well explicated within the current findings, showing that despite having either formal or informal theories of problem formation and resolution, participants were unable to effect sustainable change in

their lives. These explanations alone were insufficient to facilitate change. There was however, consensus amongst participants that it was the interaction within the therapeutic dyad that was ultimately change facilitating. These findings, if interpreted in line with BCPSG (Bruschweiler-Stern et al., 2010) theory, seem to indicate that it was the procedural knowledge (the knowing how to do something), developed out of the relationship (relational knowing) that fostered psychological change.

BCPSG (Bruschweiler-Stern et al., 2002) postulate that change largely resides in the quality of therapeutic relationship and described this processes as follows:

The more felt experiences are shared with the responses of another, the more one's thoughts and feelings are experienced as human and relational, that is, capable of being included in one's relationships with others and thereby with oneself. The sharing converts experiences of shame, guilt, or deviance into expressions of joint humanity. Mental life becomes acceptable and bearable. (p.1055)

It is the being together with another that promotes inclusiveness of various aspects of self into a more adaptive and whole structure. It is the ongoing implicit and explicit input from both participants that reorganizes their mental lives by co-creating new meanings, feelings, and intentions. Dowling (2011) refers to this process as 'lived life that exists within relationship'. He further draws parallels between Winnicott's famous statement that 'there is no such thing as a baby' (indicating the unity of the mother-baby dyad) and the notion that there may not be such thing as therapist and client, but instead "the unified relationship that is the subject of continuous change" (p. 1326). Likewise, findings from the current research indicate the centrality of relational and developmental factors in the therapeutic dyad to positive change.

More specifically, BCPSG theory conceptualizes the change process from the perspective of mother-infant, moment-to-moment, nonverbal, and unconscious communication (Bruschweiler-Stern et al., 2010). It is the intersubjective meeting between the mother and infant that generates states of affect, beliefs, and motivations. For example warm, accepting exchanges between mother and infant enable the infant to incorporate them as part of his own attempts to open-up those same forms of discourse within the reverse would happen if the mother experienced strong negative affect and tried to shut down certain forms of dialogue with her infant. This theory further explicates: "These maternal actions are implicit and

become internalized by the infant in their process form (not their content form) as ‘hate for attachment bids’, that is, profound resistance to reaching out for help” (Bruschweiler-Stern et al., 2010, p. 4-5, 2007).

Even though this implicit relational knowing resembles the preverbal functioning of infancy, Bruschweiler-Stern et al. (2010) argue that, rather than being a regression to preverbal functioning, this is one of the central dimensions of adult mental life. They claim that semiotic forms of expression, that which is conveyed explicitly, represent a superficial level of understanding. It is the adjustments between the therapist and client that carry deeper meaning; these are often conducted via eye contact, posture, silence, tone of voice, and something that is left without a comment. All of these forms of communication were recognized by the participants in the current study as being of high importance in their experience of change. Particularly, findings indicated that intrapsychic growth took place within the interpersonal space in which therapist provided developmental functions. This space, with its provision of silence and time, and the therapists’ deeply accepting and highly attuned emotional presence, enabled the clients to access deeper internal structures of the self. This was expressed by participants in seeing emotional nurturance as growth-promoting (e.g., “it was like that infant attachment, which is something that you could take with you and tap back into at times”) and healing potency of being with and being witnessed by the therapist (e.g., “when someone is watching you and just being with you, there is something healing about this”).

According to BCPSG theory, interactive exchanges between therapist and client are described as a “meeting of the implicit relational knowing” that leads to formation of an intersubjective field (Bruschweiler-Stern et al., 2010). Characteristic of this process is the immediate and direct interchange between therapist and client. This consists of action, reaction, and interaction, all of which are largely experienced on the unconscious level. This process contains ‘relational moves’, units of intentionality, and aspects of behaviour that enable inference of intention. These moments are described as “now moments/moments of meeting”, which are characterized by a feeling that something significant just happened. This conceptualization parallels descriptions of the moments of insight provided by the participants in the current study. These moments, referred to as “Aha moments” and “moments of sudden revelation”, were experienced as states derived out of deep interpersonal interaction between the client and the therapist that produced

spontaneous understanding of transformational value. The current data indicates that these unscripted and uncontrived moments lead to deeper understanding, unifying experiences on the affective, cognitive, and bodily levels.

In further elucidating this, BCPSG conceptualizes changes in the self as “an organism that are not pre-specified by the organism’s design but evolve as an aspect of an organism-context relationship... allowing for new forms and unanticipated changes in the relationship” (Bruschweiler-Stern et. al., 2010, p. 90). Thus, the process of change is understood as something ‘creative’. From these creative “moments of meeting”, new schemas or ways of being with self and others develop. The mechanism of “moments of meeting” is described in the following way: “...if grasped by the duo, it alters the intersubjective landscape of the patient’s implicit relational knowing, much as an interpretation can alter the intrapsychic landscape of the patient’s explicit knowing” (Dowling, 2011, p. 1324). Central to these moments of creative potential is the therapist’s spontaneity and free activity of the unconscious implicit mind. Current research findings seem to be in line with this theorizing, as participants stressed that moments of transformational value had a spontaneous and unexpected quality to them. In further support of this was participants’ preference for therapists who were able to think freely and respond to their uniqueness and individuality, as opposed to those who were constrained by theory and technique. This was also reflected in seeing therapists’ pre-emptive and mechanized approach to therapy largely obstructive to psychotherapy process.

The BCPSG theory also proposes that while change can occur as a result of highly charged ‘now’ moments, it is equally prevalent in small, less charged moments (Bruschweiler-Stern et al., 2010). In these instances change it is largely imperceptible and occurs in very small shifts. Therapist and client are no longer seen as two independent individuals engaged in both explicit and implicit relational processes, but instead as an entity that undergoes continuous incremental changes. Similarly, participants in this study experienced change as a continuous process that unfolds gradually overtime. They also placed emphasis on the incremental development of new structures, as taking place within the relational context.

In conclusion, the BCPSG theory, despite its complexity, has undeniable value for a deep and comprehensive understanding of the elusive and multi-faceted dynamics of therapeutic change (Bruschweiler-Stern et al., 2010). While it does not implicate any specific structures or mechanisms of change, its focus is on the present

moment of engagement between therapist and client, which is viewed as the central aspect of the process of change. Here, the self as a separate entity is temporarily ‘replaced’ with self in relationship and the meaning making is achieved in this two-person relational unity. Similarly, in the model developed based on the current data, change appears to depend upon the relational quality of the therapeutic dyad. This is evident in the emphasis participants placed on experiences that had a potential to broaden their relationship with self and others. Above all, participants emphasized the increased self-integration and coherence that developed as a result of relational experiences. These findings indicate that it was the sharing of felt experiences with therapist, that over time transforms difficult and disowned feelings into more acceptable and bearable components of mental life.

To this end, the aim was to develop a client-generated model of change, so to assist in a detailed explanation of complex and multidimensional processes occurring within the therapeutic dyad. It is therefore hoped that the proposed model will contribute to understanding of the relational processes underlying therapeutic change that are rarely addressed in any depth within contemporary theories and models.

### **Discussion and Implications for the Field**

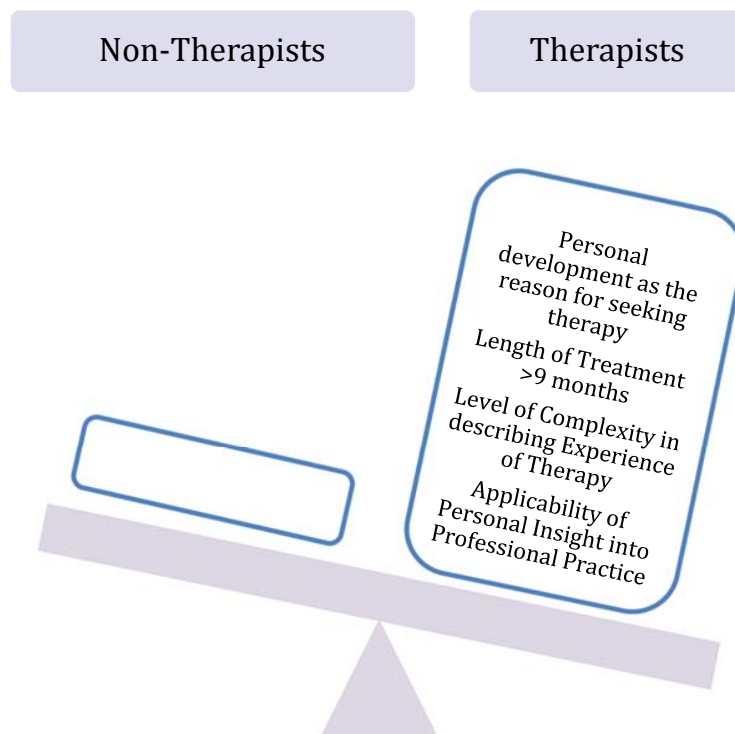
This study makes contributions to the field of psychotherapy research by expanding the concept of change from theoretically pre-determined research, or therapist based observations, to include the clinically useful psychological construct of client-generated reflections on their own experience of change. This was achieved by obtaining client data based on phenomenological explorations without a predetermined taxonomy. While previous studies have examined variables in relative isolation (e.g., singular factors such as client agency, helpful factors, or significant moments) the present research has attempted a more holistic and ecologically valid approach to investigate therapeutic change. This was achieved by taking into account all previously researched factors, along with some themes that had not been studied before (e.g., problem formation and resolution) in the context of medium-to long-term therapy.

This study explored multiple aspects of the clients’ experience of therapy and evaluated its findings by mapping them onto selected models of change. This could make research on clients’ theory of change more valuable to researchers and clinicians attempting to develop specific theoretically based therapeutic approaches. The issues central to promoting therapeutic change were studied from the

perspective of two client groups, therapists and non-therapists, and from the myriad types of therapies. Given that the same mechanisms were observed across all cases may suggest that the findings, at least to some extent, are an expression of more general trends. Based on this picture of client-generated theory of change in psychotherapy, several key findings and implications for the field emerged. The purpose of this discussion is to examine how these key findings resonate with existing research on the clients' experience in psychotherapy and how they map onto the selected models of change. Such contextualization of these findings will also lead to recommendations for therapeutic interventions and for the future research.

As has been mentioned previously, this study used therapists and non-therapists as participants, a relatively unique design. However, surprisingly, the findings revealed only minor differences between therapists and non-therapists in their experience of change in psychotherapy. The two samples provided very comparable descriptions of the change process. Differences however, were noted in the reasons for seeking therapy, with a higher number of therapists' seeking treatment for personal development rather than clinical reasons. They also, on average, stayed longer in therapy (9 months longer). This finding may indicate that psychotherapy is more acceptable amongst therapists, whereas non-therapists may find it more stigmatizing and more purpose driven (such as symptom reduction). This could be explained by the fact that therapists have greater knowledge of therapy's effectiveness as well as where to access such help. There was also somewhat greater variety in the way therapists described therapeutic change, compared to their non-therapist counterparts. This is, most likely, a result of therapists' having conceptual maps and a more extensive lexicon about psychotherapeutic change from which to draw, when describing their experiences than non-therapists. Finally, therapist-participants reported the direct applicability of the newly acquired insights to their professional practice. Figure 25 illustrates the core differences of comparative samples.





*Figure 25. Core Differences in Comparative Samples.*

It was found that personal therapy was highly relevant to therapists' professional work, a result that is consistent with previous studies (Daw & Joseph, 2007; Macran et al., 1999; Norcross, 2002; Orlinsky et al., 2005; Wiseman & Shefler, 2001). Therapists often reported an overlap of professional and personal development and recognized the value of personal therapy to their professional practice. This was experienced in two dimensions: i) experiential learning and ii) gaining a client perspective. This process of assimilating personal learning into professional practice had a particular value, because any insights were derived from personal experience. Therapists also felt that personal therapy was a pre-condition to a deep and emphatic understanding of the client's experience. These findings imply that personal therapy may have great professional benefits for therapists.

The research identified several strong elements of shared experience amongst therapists and non-therapists in terms of therapeutic change processes. All participants placed particular emphasis on the relational aspects of the therapeutic dyad. A solid therapeutic alliance, developed on the basis of a real and deep

relationship with an accepting, supportive, and non-judgmental therapist was a *sine qua non* of helpful intervention. The role and significance of the real relationship to positive treatment outcome has been well established in the field of psychotherapy research (Blatt & Shahar, 2004; Duquette, 2010; Fuertes et al., 2007; Gelso & Hayes, 1998). The current results help to elaborate these findings.

As mentioned previously, one of the most outstanding and consistent themes to emerge from this study was the pivotal role of a deep and authentic therapeutic relationship. Participants identified authentic personal engagement, where they felt understood on a very deep level, as essential to remaining in treatment and achieving personal growth; they also valued it over any specific therapeutic technique or theoretical approach. Descriptions provided by the participants offered insight into the mechanisms that foster a real therapeutic relationship that could subsequently be internalized. One core mechanism was the experience of being seen in a real and vulnerable state, where the therapist develops deep knowledge about the client. It was this very personal knowledge developed by the therapist about the client that allowed space for communication (both verbal and non-verbal) that gave rise to moments of deeper understanding.

The authenticity of the therapist was stressed as central to this process. This is consistent with claims made by some researchers, that in order for change to occur the therapist needs to experience him or herself as real and genuine, a feeling that goes beyond assuming the role of therapist (BCPSG, 2010). Participants provided various examples of moments when they experienced the therapist's realness and honesty as being highly valuable therapeutically. Of significance, were the use of humour and extra-therapeutic gestures (e.g., offering an umbrella, giving a hug on the last day of therapy) that were outside the therapeutic contract. Participants ascribed high value to these events, as they arose from the spontaneity of the therapist, and were not part of the 'paid-for-hour' interaction. These moments further facilitated dissipation of the asymmetry in the client-therapist relationship, without compromising therapeutic boundaries.

Another dimension of authenticity and realness was therapeutic competence. Findings from this study give greater insight into the meaning of therapeutic competence. The participants understood it as extending beyond provision of information; it was about communicating knowledge and skills that had been truly understood and subsequently conveyed to them in a personally meaningful way. A

competent therapist was described as someone whose solid knowledge foundation allows them to be 'free enough' to listen to the client. Descriptions provided by the participants indicated that they were able to distinguish between someone who was fully engaged with them from someone who was cognitively preoccupied with the right way of responding.

Competence also meant skill in comprehending complex issues and assisting the clients to discover their own truth, instead of 'educating them' or offering answers and solutions pre-emptively. Therapists' ability to acknowledge mistakes was perceived as another expression of competence and realness. These findings indicate that authenticity and competence are interrelated and complementary facets of a deeper construct of therapist realness. It is, therefore, a recommendation of this study that therapists are made aware that therapeutic change is not facilitated by the illusory and omnipotent image of the therapist, but rather an experience of being with someone, who while truly committed to helping, is authentic, and as such not free from making mistakes.

An important finding of this research was that participants experienced their therapist as someone who provided developmental functions and therapy as a second chance to complete psychological development. This unique finding shows that attachment to the therapist was experienced across all cases and that it formed gradually and intensified over the course of treatment, only to diminish in strength in the final stages of therapy. While the concept of the therapist as a developmental object has received a lot of attention on the theoretical level, there has been little empirical enquiry into the client's experience of the therapist as an attachment figure (Arthem & Madill, 2002; Knox et al., 1999). Existing data comes exclusively from studies on long-term psychoanalytic or psychodynamic therapy (Eagle 1995; Parish & Eagle, 2003). However, it is clear from the current study that similar attachment processes are at work, irrespective of the treatment modality and even the length of treatment.

Participants identified the processes occurring within the therapeutic dyad as providing an opportunity for re-working of early developmental functions. Their descriptions reflect the depth, intensity, and fundamental nature of parent-child dynamics. This is supported by psychotherapy literature that conceptualizes this 'parental' aspect of the therapeutic relationship from the perspective of attachment theory (Holmes, 2011; Slade, 2005). This process involved an internalization of the

therapist function. The therapist is experienced as a witnessing and assisting figure, which over time undergoes transformation from being present in external reality to becoming internalized. Analogous to attachment theory, it is suggested that the therapist's ability to provide a secure base characterized by responsiveness, reliability, and consistency, can repair disruptions of early emotional connectedness. Therefore, if this function is activated within the therapeutic dyad and therapists are cognizant of its meaning and significance, they can help clients gradually re-work these early 'templates' of self. Findings from the current research provide an optimistic view of the possibility of re-working, re-establishing, or even developing new functions within the self.

The strong sub-theme here was the realisation that this process was facilitated by the therapist's attunement and provision of containment for the unprocessed, not yet understood feelings and thoughts. This containing function involved bearing, absorbing, transforming, and interpreting material produced by the clients. This is analogous to Bion's (1963) concept of the 'container-contained'. It is significant that this concept, while having received virtually no attention from psychotherapy research, found its confirmation within the accounts provided by the participants' in the current study. These original findings point to the therapist's developmental and containing function as a universal constituent of the mechanism of change. Furthermore, in contemporary psychoanalysis this is linked to the process of the recovery of a good object, in that, the therapist who is experienced as genuinely accepting and loving, can be identified with and subsequently internalized (Brenman, 2006). Thus, in order to sustain deep personal connections the individual needs to introject, identify with, and assimilated a stable good object into the concept of self.

Irrespective of treatment modality, all clients endorsed a strong therapeutic frame as a necessary condition for these deeper developmental processes to take place. Its value and qualities were typically reflected in having a predictable and reliable therapeutic experience, with security and safety provided by the therapist. Participants talked about the importance of a 'setting' which was safe, constant, and solid. Such a frame offered protection from the potential disruptions of the outside world and enabled a more concentrated focus on the self. This, in turn, promoted the clients' greater acknowledgement of their psychological reality that was necessary for personal change and growth.

These research findings highlight the particular helpfulness of the containing and holding role of the ‘frame’ as enabling safe exploration of unsafe areas of psychological reality. In addition, there was a strong indication that not only the therapist, but the room, the time, and other aspects of the therapeutic space, functioned as a container in which disturbing material could be ‘safely stored’ and ‘left behind’ until the next session. This finding is of particular significance, because in spite of an emphasis within psychotherapy literature on the importance of a safe and consistent therapeutic setting, there are only few documented enquiries into its role from the client perspective (Birksted-Breen, 2010; Hill, 2004), and none into treatment approaches other than psychodynamic or psychoanalytic. Furthermore, to the researcher’s knowledge, this is the first study that confirms the significance of the therapeutic frame irrespective of treatment modality.

Another important finding of this research was that some forms of therapist self-disclosure had therapeutic significance. These self-disclosures typically included an expression of therapist emotions and in-session reactions. They had the potential to strengthen realness in the relationship, had an empowering effect, and often provided new contexts for learning, in that, they validated what was evoked in clients and, in turn, promoted greater confidence in their own experiences. These findings allow for a tentative set of guiding principles for helpful self-disclosure. It is important that the timing is right, there is contextual relevance, and the right amount of information is delivered. All of these require evaluation in the context of three ever-present components of the client-therapist dyad: the therapeutic alliance, transference, and the real relationship. However, the provision of adequate education regarding the parameters of self-disclosure may not be enough. Because therapy is a two-way communication between client and therapist, self-disclosures need to be guided by careful evaluation of what could contribute to the therapeutic process and the client’s therapeutic benefit at any given point. Further to this, the findings indicate that the therapist-client relationship needs to have enough strength to be able to withstand the risks arising from such exchanges.

This study provides unique insight into how clients’ experience of therapists’ self-disclosure changes during the process of therapy. These original findings revealed that during the early stages of therapy, where trust needed to be established, participants expressed curiosity about therapist’s professional credentials and personal circumstances. At this point in treatment, participants appreciated

therapist's personal disclosures, unlike in the middle stages when this caused significant distress. In the middle phase, the therapist was idealized and there was minimal tolerance for any outside intrusions, including the therapist's own disclosures. One possible explanation for this finding concerns the attachment dynamics that are strongly reactivated within the therapeutic dyad at this stage of treatment; often, the client desires exclusivity with the therapist at this point (Hurry, 1998). However, therapist personal disclosure during the final stage of therapy facilitated the transformation of a therapeutic relationship into a more real relationship. This enabled participants to transition out of this stage of treatment. The findings imply that while clients may benefit from therapist's self-disclosures in the early and final stages of treatment, in the middle phase, where deeper level work takes place, they are more likely to experience it as intrusive and detrimental to the process.

The current study indicates that clients experience change-promoting, significant moments as being relationship-oriented. This is in line with existing research findings showing the therapeutic relationship to be crucial in generating positive outcomes in therapy (e.g., Horvath & Bedi, 2002). In addition, this study offers an original contribution in delineating not only the components but also the mechanisms responsible for generating significant moments. This study indicated that these change-promoting moments had a high prevalence of affect-oriented components. This may suggest that while the relational context is central in generating positive change, it is the affective experience that fuels and sustains it. These findings further indicated that affective experiences required repetition in a reliable and safe dyad in order to evoke longer-lasting change.

More specifically, the current data indicates that insight is truly change inducing when experienced as a multi-dimensional process of alignment in the cognitive, affective, and bodily domains. Descriptions provided by the participants offer a unique window into what happens during these moments. Here, change-inducing moments occur when strong affect, body experiences, and cognitions were simultaneously activated and recognized on the conscious level. This process, when repeated over time in the presence of understanding and reflective therapist, lead to consolidation of deeper understanding responsible for lasting change. These experiences 'repeated over time' allowed for establishment of a positive feedback loop between therapist and client that instituted psychological change.

When describing significant moments, participants emphasized the emotional correlates of psychological insight. Here, change-igniting capacity emerged out of insight that contained intellectual as well as emotional components. This type of insight needs to be distinguished from catharsis or abreaction that typically generates only temporary relief (Hill & Castonguay, 2007). This was more of an integrative and consolidative process. Central here was the therapist's understanding presence and ability to engage with emerging material. This form of therapeutic presence conveyed a deep sense of alliance that went beyond a verbal level, into interaction on the non-verbal emotional level. This suggests that positive change may be generated, when the therapist can cognitively and viscerally register affective states produced by the client and process the experience within a mutually synchronized and aligned exchange.

These original findings further indicate that self- integrative moments emerge out of synchronized activity of the therapeutic dyad. These significant moments of new integrations appeared to be characterized by the therapist's and the client's active and spontaneous engagement. Participants described these moments as having a revelatory quality; they usually occurred unexpectedly, as a surprise, which seems to be a critical component of these kinds of experiences. These findings suggest that it is the therapist's state of 'not knowing' that facilitates emergence of these moments. This highlights the importance of the therapist's ability to tolerate uncertainty. Central to these moments of creative potential is the therapist's spontaneity and free activity of the unconscious implicit mind (Bruschweiler-Stern et al., 2010; Beebe & Lachmann, 2005; Thelan & Smith, 1994).

It needs to be stressed, however, that these significant moments occurred as a result of careful and lengthy clinical work that enabled clients to gradually reveal all aspects of self. These moments were more likely to develop out of contexts recognized by clients as aligned with their views and values. Therefore, the implication for therapists is to refrain from promoting their views and values, but instead assist the clients to connect with their own values and beliefs. This finding reinforces the critical role of the clients' development of their own theory in producing positive change. It also confirms the need for the therapists to adapt interventions, so they are closely aligned with the worldview of the clients.

Another original contribution of this research lies in identifying several strong elements in terms of problem formation and resolution, aspects that were not

previously studied in the context of clients' experiences of long-term therapy. Prior to entering treatment, the majority of participants reported having only a very general or 'surface level' understanding of the causes and potential solutions to their problems. However, all considered therapy as a prerequisite for change and perceived therapy as central to resolving their problems. This finding echoes research on therapeutic factors, where clients hope and expectancy is considered one of the necessary components of therapeutic change (Lambert, 2005). Analogous to other research (Gavrilovic, Schutzwahl, Fazel, & Priebe, 2005; McLeod, 2012; Nilsson, Svensson, Sandell, & Clinton, 2007), participants in this study reported that it was the understanding developed in therapy, on how particular issues were contributing and maintaining their current difficulties, that promoted change. Even in the rare instances when participants had an explicit explanation of problem causation, their initial understanding of the origins of the problem evolved and changed as therapy progressed. The most common transition was from viewing the problem as external to one self, to recognizing its internal and behavioural components.

Interestingly, in some instances there was recognition that having a theory of problem causation was not sufficient to facilitate change. At the same time, participants acknowledged that these explanations, although not necessarily adequate, often served as a "springboard" to deeper and more accurate explorations. These findings indicate that client's informal theories, even if inaccurate, serve as a starting point and provide a solid foundation to begin therapeutic work. One important finding was that having an initial theory of problem formation played a facilitative role in establishing a positive therapeutic alliance. That is, it was not the explanation itself, but the rapport it generated between the client and therapist that was change promoting. This finding suggests that therapists' should routinely explore clients' understanding of the nature and origins of their problems.

Of critical value, was the finding that the lack of an explicit theory of problem resolution was equally prevalent amongst therapists and non-therapists. However, most participants in both groups exhibited some degree of intellectual understanding, while at the same time reported 'not really knowing'. This was particularly true where they were seeking to address difficulties that originated in early developmental stages; often this knowledge was only available implicitly. This finding is supported by recent research on the role of explicit and implicit knowing



in the change generating process (Beebe & Lachmann, 2002; BCPSG, 2010; Grebow, 2010; Fonagy & Target, 2007). Explicit, conscious understanding or insight is considered secondary, an addendum to change that originally occurs on the unconscious level of implicit relational knowing.

Findings from the current study echo those contemporary psychoanalytic theories which postulate that the experience of what is not yet consciously conceived ('implicit knowing') is central to psychological change. This undergoes transformation through the process of therapy into something more explainable and visible. It is the interaction between the therapist and the client that allows for these implicit, often preverbal, and pre-reflective experiences to be transformed into explicit, declarative, and dialogic experiences (Beebe & Lachmann, 2005). Findings from the current study provide tentative support for this theory, by indicating that clients' pre-treatment understanding of the problem formation and resolution, along with their experience of the process of change, followed the trajectory of implicit knowing being transformed via relationship into an explicit knowing. Examples that elucidated this trajectory included discovering previously unknown aspects of self: "finding out so much more along the way was very important"; and experiencing previously unfelt affect: "I didn't feel that intensity until in the four walls and with another person".

There is strong evidence that the strength of the therapeutic relationship, the length of treatment, and rate of success is positively correlated with congruence between the client's beliefs about the causes of the problem and the treatment approach (Ahn & Wampold, 2001; Duncan et al., 2010; Safran & Muran, 2000; Wampold, 2001). The current study indicates that participants express some degree of preference for the model of treatment. Therapist-participants had stronger and better-formulated views than non-therapists, who instead relied more on an implicit and intuitive understanding of what they perceived as helpful. Importantly, findings also showed that strong allegiance to a treatment modality did not prevent clients from having recurring doubts about treatment effectiveness. Inadvertently, this raises concerns regarding treatment effectiveness in the context of weaker allegiance to treatment modality. This suggests that the degree of allegiance could significantly effect clients' motivation and hope regarding treatment effectiveness and therefore impair their ability to remain in treatment.

Participants also expressed preference for therapists who either shared the same worldview or were willing to explore and incorporate the client's perspective into treatment. These findings are compatible with a substantial body of research on the impact client treatment expectations and preferences have on the outcome and process of therapy (Arnkoff, Glass & Shapiro, 2002; Greenberg, Constantino, & Bruce, 2006; McLeod, 2012; Swift & Callahan, 2009). A review of 26 controlled studies showed that clients who received a preferred therapy had 50% fewer premature dropout rates and reported substantially more beneficial outcomes at the end of therapy (Swift & Callahan, 2009). A study by Handelzalts and Keinan (2010), further showed that clients who believed they had actively chosen a preferred mode of treatment reported significantly more improvement than the control group, which also received their preferred therapy, but were not told this.

In the current investigation, several notable change-obstructing factors were found. First, the most unhelpful were factors that impaired the therapeutic relationship. These included the therapist's limited attunement and negative judgment of the client, both of which contributed to a lack of psychological safety. Judgment typically was strongly feared in the early stages of therapy, before trust solidified. Previous studies have also shown that a client's decision to reveal secrets early in the process was mediated by a fear of the therapist's judgement (Kelly, 2000; Kelly & McKillop, 1996). However, this study offers original findings in terms of the effect these change-obstructive behaviours have on the client at different stages of treatment. For example, in later stages of treatment, participants discussed their fear of misattunement, which was characterized by a lack of emotional connection, often resulting in a breakdown in communication. Lack of attunement seemed to play a more significant role in the later stages, where deeper level work was underway. During these phases, clients were greatly sensitive to even subtle signs of lack of affect attunement. The current study adds to the existing research, by elucidating some therapist characteristics that are likely to have a detrimental effect on their clients; these included: an uncaring, defensive, and controlling attitude, and insensitive and intrusive interventions. These misattuned behaviours, at times, directly influenced deterioration, whilst at other times impeded progress that might otherwise have taken place.

Second, inaccurate or premature interpretations were experienced as detrimental to the therapeutic process. Freud (1919/1958) actually proposed that

analysts should refrain from interpretations until a strong therapeutic alliance had been established. He argued that premature interpretations were likely to trigger strong resistance in the client, especially if they were correct. More recently, researchers have found that premature and higher level interpretations lead to poor treatment outcomes (Crits-Christoph et al., 2009). The early use of interpretations was also shown to have a detrimental effect, as it set the therapist up as an expert on the client's experiencing, causing the client to feel disempowered (Greenberg, Rice, & Elliott, 1993).

Third, clients found the imposition of an excessive structure or one that was too unstructured hindering to the therapeutic process. While a higher number of participants' found a lack of structure and direction disconcerting, for some it was the therapist's exertion of too much control over the content and process of therapy that stalled the treatment. Findings, however, indicated a disproportionately higher number of complaints regarding lack of structure. This is potentially associated with the longer length of treatment, which may lend itself to the provision of a less structured form of treatment. This finding suggests that therapists may need to attend to this issue by periodically inviting clients to re-visit treatment progress and their experience of therapy.

Fourth, a significant number of participants identified the therapist's inflexible, pre-emptive, and assumptive ways of thinking as unhelpful. An impersonal, prescriptive approach and provision of immediate solutions were identified as detrimental. This frequently invoked a sense of being objectified and misunderstood or understood only in a very superficial manner. Given that participants attended medium-to long-term therapy, it is perhaps not surprising that they prioritized provision of time over any 'quick fix'.

Previous studies have found that poor client outcome was associated with lower number of sessions and higher therapist caseload (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). In addition, research has also suggested that it is the rigid application of technique that interferes with positive change (Casonguay, Boswell, Constantino, Goldfried & Hill, 2010; Hayes, Castonguay, & Goldfried, 1996). Therapists adherence to prescribed and rigid interventions increased when confronted with a rupture in the alliance, wherein the stronger the client's resistance to the technique, the greater the therapists insistence on it. Such defensive adherence

exacerbated the rupture in the alliance, ultimately leading to poorer outcome (Hayes, Castonguay, & Goldfried).

One element that was particularly unhelpful, was the experience of being responded to in a “rushed” way. This conveyed to the clients that they were not worthy of being fully understood, with all of their complexities and idiosyncrasies. This was also referred to as an “assembly line feeling”, where individuality, uniqueness, and sense of self-discovery had been lost. This is linked to another finding, whereby therapists’ rigid and mechanical adherence to therapeutic technique was very detrimental. This is particularly relevant in light of the current changes to health care system, where manualized, content-driven, and session-limited forms of treatment receive greater endorsement than longer-term, open-ended forms of therapy. This research finding also has implications for therapists’ education and training, with regard to adherence to technique. Therapists need to be mindful that clients find mechanised adherence to technique as depersonalising and instrumental. This implies that therapists need to develop the ability to transition from explicit to implicit use of theory and technique. In other words, theory and technique, rather than being prioritized and imposed over the client’s experience, should implicitly accompany it.

Another potentially important recommendation from this study is for therapists to recognize that clients differentiate between acceptance and reassurance. The experience of being accepted, supported, and not judged was indispensable to psychological change. At the same time, reassurance was experienced as hindering to that process. Participants found reassuring expressions to be placatory and serving only as provisional attempts at addressing their difficulties. Reassurance, along with short-term solutions, were often equated with a lack of a deeper level acceptance. It was the consistent experience of being accepted that evoked a deeper process of self-reclaiming that could be internalized. This may be particularly relevant to clients in medium-to long-term therapy, whereby deeper change-generating processes are at work.

Finally, difficulties surrounding the termination phase were found to be detrimental. Many participants experienced the end of therapy as confusing and largely unacknowledged. Rushed endings were marked by feelings of ambivalence and regret. Even in instances where the therapist initiated discussion about termination, there was insufficient processing of emerging issues. In some instances,

premature, incomplete, and insufficiently processed terminations had a potential to negatively colour the overall experience of therapy.

Premature and unilateral endings also triggered off powerful feelings of abandonment and lack of control. According to developmental theories, successful termination includes working through and resolving early ties and achieving separation and individuation (Burgner, 1988; Delgado & Strawn, 2012; Sandler, Kennedy, & Tyson, 1980). Findings from this study, suggest that clients' negative reaction to premature termination possibly reflect interruption of the psychological re-working of earlier developmental stages of separation and individuation from parental figures.

Unlike in time-limited forms of therapy, in which session frequency and duration of treatment are often defined at the time of initial contact, longer-term therapy does not have a set termination date. This leaves the therapist with the complex task of assessing the client's readiness for termination. Participants indicated a need for greater openness on the part of the therapist in initiating conversations around termination. They typically wished for greater acknowledgement of the significance that termination of therapy had for them; they often felt unprepared and required more time to be allocated to this phase of treatment. Termination of therapy elicited high levels of anxiety and ambiguity. Therefore, it may be important to address clients' fulfilled and unfulfilled expectations about the outcome of therapy and allow sufficient time to work through their feelings of loss of the therapist. Participants stressed the importance of mutual negotiation of termination, as well as assurance of the therapist's availability post-termination. For some participants, a gradual reduction of the sessions was necessary, before reaching complete termination. Others chose to remain in a maintenance phase, where they saw the therapist a few times a year to 'touch base'.

There is a very limited data on how effectively therapists manage the termination phase. Available findings suggest that negative experiences of termination are characterized by a lack of discussion of termination-related emotions or review of treatment goals and gains (Knox et al., 2011; Roe, Dekel, Harel, & Fenning, 2006; Quintana & Holahan, 1992). Likewise, the current study indicates that termination of longer-term and open-ended therapy receives an insufficient level of attention from therapists. Termination and post-termination are the least understood phases of treatment and much of the existing literature is based on

theorists' and researchers' assumptions of how clients are expected to end therapy (Salberg, 2010). The findings from the current study suggest a need for more careful and effective management of the termination stage of therapy.

This study revealed the importance of dedicating a sufficient amount of time to the final phase of treatment. This finding has important implication for best practice, as it shows that unresolved terminations often leave clients' with complex residual feelings of anger, resentment, as well as a sense of loss of the therapist. This is particularly important in light of the research findings on the post-termination phase, suggesting that clients typically mourn the loss of the therapist and struggle to create internalizations of the therapeutic relationship that will support their capacity to manage life without their therapist's guidance (Craig, 2002; Orgel 2000; Schlesinger, 2005). From the best practice perspective, these findings imply that clinicians need to acknowledge that the end of therapy holds great significance to clients and often has a potential to jeopardise treatment gains. For clients, it is an end to a very important relationship that requires careful preparation. This is a complex process, unique to each therapist-client dyad. It is a phase of treatment, not a singular event, and therefore should be treated with as much consideration as any other phase of treatment. It is hoped that these findings help to challenge any assumptions that may constrain therapists in their practice.

In summary, these recommendations are designed to raise greater awareness amongst researchers, theorists, and clinicians of the clients' subjective experience of psychotherapy, with particular focus on factors and processes that generate therapeutic change. It is hoped that these insights will assist clinicians in developing greater sensitivity to factors viewed by clients as change facilitating. Further discussion on the implications of these findings for clinical practice and future research are provided in the last section of this chapter.

### **Limitations of the Current Study**

This study attempted to address several gaps in the psychotherapy literature, by exploring the client's perspective on the experience of change. Data were bound by the extent of participants' individual experiences and attitudes towards the investigated phenomenon. As such, findings must be interpreted in light of several limitations. First, the qualitative design and analysis, although appropriate for exploring intangible psychotherapy process variables that constitute psychological change, has limited generalizability (Hill & Knox, 2009). In addition, data derived

from qualitative research, while useful in generating hypotheses, cannot provide basis for causal inferences. According to Smith (2004), due to the largely subjective nature of qualitative analysis, results can only ever be treated ‘tentatively’. Therefore, the findings obtained in this study cannot be interpreted as representative of the experiences of all individuals who engage in medium to longer-term psychotherapy.

The majority of participants had undertaken therapy prior to the therapy experience explored in this study. One of the reported reasons was lack of sufficient resolution of the issues for which they were seeking help. This was often accompanied by the lack of a ‘good match’ with the therapist, treatment modality, as well as insufficient readiness for change. In terms of the reasons for undertaking such protracted therapies participants reported combination of symptom reduction and deeper levels of self-understanding that were not critical to their functioning. However the issues for which they were seeking treatment in the first place would not classify as highly complex or clinically severe. It might well be that investigated cohort constitutes a particular type of therapy users who are seeking deeper level engagement with their own psychology and do not perceive symptom reduction as the only constituent of change. Therefore the results may not be generalizable to other clients who are less inclined to engage in longer-term self-exploratory form of treatment or clients from a more severely dysfunctional clinical group.

The subjectivity inherent in the IPA method of enquiry raises further issues around replicability and reliability of the findings generated in this format. In part, this is related to the fact that no two researchers’ analysis of the same data set would reach the same conclusions (Brocki & Wearder, 2006). In addition, inherent in the double hermeneutic nature of IPA are researchers’ personal biases which may influence the interpretations of participants’ experiences. That is, the researcher’s own prior experiences, assumptions, and preferences influence, to some extent, the interview approach and subsequent data analysis and interpretation. In spite of Yardley’s (2008) assertion that issues of reliability and replicability are of limited relevance to the interpretative form of research such as IPA, several means were employed to limit researcher bias and stay as true to the intended meaning of the data as possible.

To combat limitations inherent in qualitative research, the current study followed Yardley’s (2008) guidelines that were addressed in detail in the method

section. Some of these measures included: i) an ongoing effort to maintain neutral input throughout the process of the interviews (e.g., asking open-ended questions, probing rather than leading the participants), ii) having the sample of the data being reviewed and coded by another researcher, iii) through conducting disconfirming case analysis; iv) through ongoing discussion of emerging themes and category formations with research supervisor, v) through undertaking an intra-rated comparison achieved by coding a sample of the same data twice in a 6 monthly interval, and vi) providing ample quotations to allow readers to evaluate the category formation process.

IPA research precludes use of large sample sizes, therefore reducing its representativeness and generalizability value. While the sample size of the current study,  $N=24$ , would be seen as too small to uphold any nomothetic value of the research, it would also be considered as too large for a complete adherence to the IPA principles of data analysis. Given the nature of IPA analysis it would seem more appropriate to work on a smaller sample and over a series of interviews with each participant, to allow for in-depth exploration of some of the material that arose in the initial interviews. These contentions about sample size have been addressed by Smith, Flowers, and Osborn (1997): “IPA has a different epistemological commitment to that of mainstream psychology where issues of reliability, sample size and so forth have particular status. And even single case can make a contribution to the wider field, for example, in terms of problematizing existing concepts or helping to develop ways of looking at new areas of study” (p. 87).

In addition, the idiographic nature of IPA along with its main principle of purposeful selection of participants who represent a perspective on a phenomenon under investigation may limit its applicability to any larger population. While purposive sampling, unlike a ‘convenience’ sample, allows for transferability of findings, it may at the same time attract participants who see this as a platform to voice strongly held views on the topic in question (Morse & Richards, 2002). Such self-selection-bias, while not exclusive to qualitative research design, needs to be taken to account as potentially placing some limitations on transferability of findings in this study.

Another potential limitation of this study, and one typically levelled at IPA research format, is its lack of consideration for the social, historical, and cultural contexts of participants’ experiences. This wide-ranging context was not accounted



for as it simply went beyond what was considered practical, for this already very comprehensive research. It is hoped that with the growing applicability of IPA in to the psychological enquiries, future studies will take into consideration these wider aspects of participants' lived experience.

### **Future Directions**

In spite of extensive empirical studies spanning past four decades, the question of how psychotherapy leads to change remains inconclusive. Future research ideally should continue exploring mechanisms underlying this process, particularly as findings from this study point to a great complexity in these mechanisms. In order to facilitate this, the current study could be replicated on bigger samples to establish whether the findings can be generalized. More thorough explorations of the complexities of change could also include obtaining data from multiple perspectives (e.g., clients, therapists, researchers, and independent reviewers), both in long and short-term treatment. In addition, there has been little work done comparing the same treatment modalities in longer and shorter-term formats, to see if change processes and outcomes do differ and, if so, in what ways. This appears to be of particular significance in the context of the current health economy that limits length and availability of psychotherapy services, as well as endorsing some treatment modalities over others.

In order to build on the current findings regarding stages of change, future research should also consider comparing the accounts of clients during treatment with their accounts some time following termination, to see how retrospective recall differs from accounts obtained at the time of therapy. This could help not only identify development of particular stages of change during and post-therapy, but also could lead to further investigations of post-therapeutic developments of change including information on how changes are consolidated over time. It would be valuable to include a control group, to see if reported changes are also occurring over time without the assistance of a therapist. This could lead to interesting explorations of qualitative differences between treatment induced and spontaneously occurring change processes.

Another important finding that could be expanded further is the function of the therapist as a developmental object. This study showed that irrespective of the treatment modality and even the length of treatment, participants experience the

therapist as an attachment figure. In a further attempt to broaden our understanding of this finding, research could address the question of what are the main characteristics of the therapist as an attachment figure and in what ways does the attachment relationship influence the process of psychological change. Further controlled studies could employ the use of adult attachment measures to gather more specific data on mechanisms underlying the development and function of the attachment relationship. Although this process would be somewhat lengthy, it would allow complex change generating processes to be explored in a systematic and detailed manner, enabling comparison between various treatment modalities and lengths of treatments.

Final considerations of this study were also concentrated on the enhancement of education, training, and service delivery in psychotherapy treatment. In light of the current findings, which clearly indicate the significant benefits of personal therapy for therapists, it seems that studies addressing the impact therapy has on therapists' own work is an important avenue for further work in this area. Above all, the results from this study may serve as a comprehensive foundational set of qualitative data on clients' experience of change in psychotherapy that could be built upon and expanded by subsequent studies. It is hoped that these findings can be used to modify therapeutic interventions and to change practice protocols in the public health settings (Smith, Flowers, & Osborn, 1997). Given that there is an observable trend in greater use of IPA amongst researchers studying consumer based perspectives in mental health, contributions to the field will inevitably increase via accumulation of these detailed data.

## **Conclusions**

A substantial amount of data in psychotherapy research indicates client to be the most potent source of therapeutic change (e.g., Lambert, 2005; Duncan et al., 2010). It is critical, therefore, that we learn more about how therapeutic change occurs from the clients perspective and what factors account for that change. While there has been considerable research interest in regards to treatment process and outcome, studies that have investigated these issues have tended to concentrate on singular aspects of change, often using standardized forms of assessment and have rarely explored the context of longer-term treatment. This in-depth qualitative inquiry into the client's perspective on the nature of change provides a direct

window into what can facilitate this process in longer-term therapy, which in turn, may lead to a better understanding and, ultimately, the improvement of psychotherapy.

This study represents one of the first comprehensive attempts to examine clients' experience of the process of change in longer-term psychotherapy. Results obtain in this research demonstrate that previous understandings of what these processes and facilitative factors are is incomplete. Current findings point to the complexity of clients' experience of change and centrality of the therapeutic relationship to this process. Change was experienced as a gradual development of new structures, as opposed to distinct stage-like phases of transition. At the same time change-inducing moments were experienced as a multi-dimensional process of alignment in the cognitive, affective, and bodily domains. The current data indicates that these moments of insight emerged spontaneously out of deep and authentic interaction between the client and the therapist. Furthermore, research findings suggest that the therapist provides a developmental function and therapy can offer a second chance to complete psychological development. Finally, the results, herein, indicate that these processes are at work, irrespective of the treatment modality and even the length of treatment.

The overall goal of this research to broaden understanding of the change generating processes in psychotherapy was met. The examination of the sample of therapists and non-therapists from myriad types of therapies offered clinically valuable insights into the clients' experience of change. Given that the same mechanisms were observed across all cases, it is likely that the findings are an expression of more general patterns of change in longer-term therapy.

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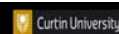
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## Appendices

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### APPENDIX A PARTICIPANT INFORMATION SHEET

My name is Magdalena Goryczko. I am a student currently enrolled in the PhD (Counselling Psychology) at Curtin University. I am undertaking research investigating the client's perspective on the nature of change in therapy. I am interested in exploring how therapeutic change occurs and what factors account for that change as perceived by the client. The client's perspective on therapeutic change has not been a major focus of previous research. Therefore it is hoped that this study, by exploring client views on the nature of change, will contribute to the advancement of psychotherapy practice, training, and professional education of psychotherapists.

With this in mind I wish to interview individuals who have attended therapy for a period of at least 6 months and have completed treatment in the previous 6-12 months. The interview will take between 1-2 hours and will be recorded in audio. The focus of the interview will be to find out how you see change happening in therapy, what were the most helpful and unhelpful things, what were some of the most meaningful moments, how you used therapy sessions, and your thoughts about what contributed to your problems and what helped in dealing with your problem(s).

The information you provide will be kept separate from your personal details, and only I will have access to this. The interview transcript will not have your name or any other identifying information on it and in adherence to university policy, the interview tapes and transcribed information will be kept in a locked cabinet for seven years, before it is destroyed.

Your involvement in the research is entirely voluntary. You have the right to withdraw at any stage without it affecting your rights or my responsibilities. When you have signed the consent form you have agreed to participate and allow me to use your data in this research.

**I would very much appreciate your involvement in this research.**

If you are willing to participate, please contact me. My details are below. You may also contact my project supervisors if you have any further questions about the project.

**This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 21/2010). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing [hrec@curtin.edu.au](mailto:hrec@curtin.edu.au).**

## APPENDIX B

### CONSENT FORM

1. I have read the information provided to me about the study exploring client's perceptions of change and acknowledged that I have been informed about the nature and purpose of the study and what my participation involves.
2. I understand that my participation in this study will involve completing an interview consisting of questions related to my experience of therapy, which will require approximately two hours of my time.
3. I understand that my participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving any reason.
4. I understand that I am free to ask any questions at any time. I am free to withdraw or discuss my concerns with the researcher.
5. I understand that the information provided by me will be held confidentially, such that only the researcher can trace this information back to me individually. The information will be retained for up to five years following the conclusion of the study when it will be destroyed. I understand that I can ask for the information I provide to be deleted/destroyed at any time and that upon my request I will be given access to the information.
6. I have been given the opportunity to ask questions.
7. On the basis of the above information, I agree to participate in the study outlined to me.

I, \_\_\_\_\_(NAME) consent to participate in the study

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## APPENDIX C

### INTERVIEW SCHEDULE

How would you describe your experiences of being in therapy?

In what ways do you think you have changed as a consequence of being in therapy?

How do you believe these changes have come about?

How much of the improvement was due to therapy versus other factors?

Could you describe yourself at the beginning, middle and at the end of therapy?

What would you see were the stages you went through?

What was helpful about therapy? How would you describe these aspects of psychotherapy?

*prompt: In what ways did you see yourself/therapist/therapy process being helpful in attaining your goals (therapeutic change)?*

What was unhelpful about therapy? How would you describe these aspects of psychotherapy?

*prompt: In what ways did you see yourself/therapist/therapy process being unhelpful in attaining your goals (therapeutic change)?*

Have you experienced any significant moments in therapy associated with change?

Can you recall any moments that left you thinking or feeling different about yourself and/or your situation?

Have you experience any empowering moments in therapy?

Did your therapy provide the opportunity for new learning experiences, or for learning through experiences? *prompt: If so, what kinds of things contributed to those experiences?*

Have you experienced any moments in therapy when you and your therapist were fully real with one another?

Have you experienced any moments in therapy when you felt something very deeply?

Did you think it was important?

Have you experienced any moments in therapy when you changed or have noticed a change in your thoughts and ideas? Did you think it was important?

How were you using psychotherapy to change?

*prompt: what were you taking away that helped you improve and change?*

If you were disagreed with your therapist's interpretations and suggestions what did you do?

*prompt: Did you tell your therapist? If not, why didn't you tell?*

Were you unhappy with any aspect of therapy? *prompt: If yes, what did you do? Did you tell your therapist? If not, why didn't you tell?*

Were there things that you would withheld from your therapist? *prompt: If so, why?*

Prior to entering therapy did you have some explanation of what is causing the problem?

*prompt: What role did this explanation play in your therapy?*

Did your own explanation of what was causing the problem(s) changed in any way as a result of being in therapy? If so, how?

Prior to entering therapy did you have any idea of what may help to resolve your problem(s)?

*prompt: What role did these ideas played in your therapy?*

*prompt: Have they changed in any way as a result of being in therapy? If so, how?*

## APPENDIX D

### QUESTIONNAIRE

#### Demographic Information

What is your occupation?

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What is your country of origin? \_\_\_\_\_

#### Therapy Information

Have you engaged in therapy prior to this one with another therapist? If so, for how long? \_\_\_\_\_

When did you complete that prior therapy? \_\_\_\_\_

How long since you have completed therapy with your most recent therapist?

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How many months (or years) did your most recent therapy last?

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What is your most recent therapist's theoretical orientation? (you can chose more than one)

Psychoanalytic

Emotionally Focused

Psychodynamic

Solution Focused

Behavioural

Cognitive-behavioural

Existential

Narrative

Integrative

Eclectic

Humanistic

Do not know (not aware)

Other (Please state) \_\_\_\_\_

## APPENDIX E

### INTER-RATER COMPARISON – EXTRACT

Original Transcript	Emergent Themes	Super-ordinate Themes
<p>The first question, is how would you describe your experience of being in therapy?</p> <p>I mean, seven years is such a long time that it varied over the years and there was different phases, different intensities. I mean, depending on the nature of what I was discussing in therapy meant that it was more or less intense. <b>This actually relates to another question I have, maybe if you could think about yourself at the beginning, middle and the end of therapy. That could be probably easier with such a long --</b></p> <p>I mean, in the beginning, I mean it progressed really well. You know, there were never sort of major issues that I was -</p> <p>- Basically my thing for going to therapy was because I'm a therapist myself, so it was about self-development, self-knowledge, insight and all that sort of stuff. So, the first bit progressed really well, and then obviously as life happens and things come up, you know, deaths, separations and all that sort of stuff, you know, that became the grist of the mill. Probably the last couple of years of therapy I switched from once a week to twice a week. I was also using the couch as well, so initially it was once a week face to face and then—I can't remember when I started using the couch, probably around the last couple of years—later twice a week. That intensified the therapy quite a lot.</p> <p><b>So, actually 'using the couch' meaning you were lying on the couch and not seeing your therapist, not facing your therapist?</b></p> <p>Yeah, so I was lying on the couch and my therapist was sort of to the side, so I could see, you know if I turned my head, but she was out of my direct eye line.</p>	<p>Differential phases and intensities</p> <p>Significant progression at the beginning</p> <p>Life issues as the grist of the mill</p> <p>Increased frequency of sessions intensified the therapy</p> <p>Use of couch intensified therapy</p>	<p><b>Intense growth facilitating experience</b></p> <p><b>Model specific interventions</b></p>

**Comment [DC1]:** Not sure if this super-ordinate theme speaks about the intensity and difficulty in termination... seems to fit better with INTENSE GROWTH FACILITATING EXPERIENCE, I think.

<p><b>And that intensified the whole experience?</b> Yeah, plus also some of the issues that I was dealing with along the way.]</p> <p><b>And at the end of therapy?</b> The end, I mean it was my decision to end. My therapist was going away overseas, but I mean from her perspective we could have continued using information technology like Skype and face-to-face videoconferencing, but it was my decision to end at that point. It was still pretty intense even towards the end because we had gotten to know each other so well, so that in itself was difficult, you know, the ending.</p> <p><b>Yeah, seven years is a long time.</b> Yeah, it seems like it when I think, about it, but it went quite quick, to be honest.</p> <p><b>From once a week to, or it was more often than once a week initially?</b> No, for about the first four or five years it was just once a week, yeah. And the last couple of years, twice a week.</p>	<p>Therapy as a very Intense experience</p> <p>Difficult termination</p>	
<p><b>In what ways do you feel you have changed as a consequence of being in therapy?</b> Oh gosh! Big questions! I don't know if I'm the best person to answer. Maybe other people would maybe see changes. I mean, I think I'm more self-aware. I think I have much more insight. You know, when something is really pressing my buttons, I usually know what buttons are being pressed and why and for what reason and usually where that comes from. So, it is like, 'Oh okay, here is that old chestnut again' yeah, and I sort of smile to myself and, 'Okay' you know. So there is a lot more insight into what makes me tick, even finding out some of those things that I never realised about</p>	<p>Increased self integration</p> <p>Additional and new perspectives</p>	<p><b>Cohesion and continuity of the self</b></p>





<p>I've been thinking about this because obviously thinking about this interview and what you might ask me, because I'm thinking I have ideas because I'm a therapist myself when I am working with clients, but what worked for me as a client, you know, I think is also quite individual. What brought about these changes? I mean, obviously because of the nature of my therapy which was psychoanalytic psychotherapy there was a lot of free association, a lot of dream work, a lot of sort of work with unconscious material, a lot of work around the transference. I think just the pure process of working through. Like, there were some things that, you know, my therapist would have said to me about 40 times but it often took a while for it to go, 'Oh, that is happening again' or 'there it is' or 'oh, I'm doing it again.' So, I think having space to notice that and see the pattern over time and feel it and sort of be able to recognise it.</p> <p><b>So some repetition as well?</b></p> <p>Yeah, so the whole working through of that. You know, it was not like the therapist would say something once, 'Ah hah!' light bulb goes on, never do it again. You know, it doesn't work like that—if only! I mean, there were moments when, you know, she had probably been saying the same thing to me for years but maybe she said it in a different way or something just resonates and it is like, 'Oh! Yeah, now I see.' But, yeah, it was more that giving of space. I mean, I enjoy working with that whole transference/counter-transference as well. That intrigues me and I was always interested whenever she would offer some interpretations around the transference. I mean, on the other hand, I'm thinking often things that really moved me in therapy were</p>	<p>Working with unconscious material</p> <p><i>'Patterns repetitively considered'</i> - Therapy specific interventions</p>	<p><b>Experiencing self at deeper levels</b></p> <p><b>Change Facilitating Strategies</b></p> <p><b>Intra-psychic and interpersonal space</b></p> <p>Being given space for intense focus on self</p>
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**Comment [DC4]:** This theme didn't quite nail it for me... I hear more like "Interpersonal Space for Deepening of the Intrapersonal Experience." Just my two cents worth! Same applies for others when it appears later as well.

**Comment [DC3]:** No, this was on the interpersonal dynamic relations of the therapist and client?

<p>and I didn't have an umbrella and she offered me to take an umbrella. She said, 'Take this and bring it back next week', so little things like offering, for example, if she was going on a particularly long break and depending on how intense the therapy was, sometimes she might offer me a little memento or something from her office, you know, just to carry or keep with me as like a transitional object.</p> <p><b>Yeah.</b></p> <p>So, a lot of the human gestures were also important as well.</p> <p><b>What else?</b></p> <p>Towards the end, like, when I knew we were going to be finishing up, because I think we had a couple of months where we knew we were going to end, I found my therapist more sort of self-revealing about herself. I actually found out probably more about her in the two months than I did in the previous whole seven years. I've got two dogs and they were an important part of often what came up in therapy, and I found out she had a dog. It was like, 'Oh wow! You have a dog too.' So, yeah, I mean that was quite moving for me almost to find out even small bits about her personal life, et cetera.</p> <p><b>You have mentioned space and you talked about transference and counter-transference. Can you say a bit more about that?</b></p> <p>I mean, I think all therapists are different. I found my therapist particularly silent sometimes. And, I mean, sometimes that would annoy me and sometimes it would be nice just to be able to think and gather my thoughts and say what I wanted to when I was ready. So, there is that sort of space, but I think she never sort of—what is the word?—emotionally or energetically intruded. I think, as well, even not being in her direct eye line sometimes gave me space.</p>	<p>Human gestures</p> <p>Internalisation of therapist</p> <p>Emergence of a more real relationship</p> <p><b>End phase – Consolidation</b></p>	<p><b>Transforming experiences</b></p> <p><b>Therapist as developmental object</b></p> <p><b>Intra-psychic and interpersonal space</b></p>
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<p>Yeah, I was just thinking about what you have said earlier in terms of moving onto the couch and how it intensified this whole experience for you. So that was the space as well, yeah.</p> <p>Yeah, I mean, obviously that does encourage the transference because if you are saying something and you can't immediately check out the person's expression, body language, it is like, 'Oh! Are they judging me? Are they frowning? What are they doing?' so there is that whole encouragement of that sort of material. But I think it was more a sense of just over time there wasn't a rush that we had to get this done in, you know, six sessions, twelve sessions, one year. You know, we were in for the long haul and she was there, whatever.</p> <p><b>And that is the sense of space as well, right, that you are not confined to a certain number of sessions that you can, yeah.</b></p> <p>Yeah, yeah, absolutely! Also, I always had the feeling that she was never going to say to me, 'Oh I think you are okay now. How about let's us finish up?' It was always going to be a mutual negotiated decision.</p> <p><b>And that was important?</b></p> <p>Yeah, I mean there were obviously times when I thought, 'Oh I think I am done now' you know, but she would interpret some resistance, yeah. Yeah, it is hard to sort of define. I mean, it is such an abstract concept and it is also a feeling as well, like, an internal sense of being given space, never crowded, rushed, pressured or anything like that.</p> <p><b>And was that always comfortable to have that or - -</b></p> <p>Oh not at all, no.</p> <p><b>No. I can just imagine that having that space can be very</b></p>	<p><i>Use of couch intensifies transference -&gt;</i></p> <p>Model specific interventions</p> <p>Silence and time as space</p> <p><i>Ending as a mutually negotiated decision</i></p> <p>Being given space for intense focus on self</p>	<p><b>Change Facilitating Strategies</b></p> <p><b>Intra-psychic and interpersonal space</b></p> <p><b>Intra-psychic and interpersonal space</b></p>
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<p>Yeah, yeah, often there was a sense that I would say something and it was like, you know, I was thinking, 'Is she going to respond to that? Say something!' Almost like 'Feel that' yeah, yeah, but I think also in sitting with whatever it was that was happening was also important as well.</p> <p><b>Do you think that that increased over time, the ability to sit with whatever it was? I would have imagined that that --</b></p> <p>Yeah exactly, yeah. I mean the other thing that I think, just going back to something that I was talking about earlier, the things that, you know, those human gestures, like my therapist had a very strict policy around cancellations. You had to give a certain amount of notice, otherwise you would be charged a missed session, and there was one time when I was due to have a session, but I was actually hospitalised and I thought, 'Crap! I can't go. I'm going to have to cancel and what if she charges me a missed session?' and she said, 'No, of course not. I'm not going to charge you.' So, again, even though I would have been willing to pay because that was our contract, that was what we had agreed, there was a real thankfulness and a real gratitude because she could acknowledge that this was an exceptional circumstance, yeah.</p> <p><b>So there was this understanding that you would expect from someone really?</b></p> <p>Yeah, yeah. That there was also like a flexibility and understanding and not just, 'Well, this is a business arrangement and you didn't keep to it, so I'm going to charge you' yeah. So, again, it was a real sort of human gesture, I thought.</p>	<p>Fear of being judged</p> <p>Human gestures</p> <p><i>Extra-therapeutic events imbued with special meaning</i></p> <p><i>Human gesture imbued with special meaning</i></p>	<p><b>Impaired therapeutic relationship</b></p> <p><b>Transforming experiences</b></p>	<p><b>Comment [DC5]:</b> Sorry, I don't quite agree w this super good update theme for this segment... it feels more like ambiguity of the interpersonal space to me...</p>
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<p><b>Okay, let's have a look at the next question. How much of the improvement was due to therapy versus other factors?]</b></p> <p>I don't think you can tell. Would I have changed anyway as I matured or grew older or became more confident anyway, you know once I transitioned from my 20s and 30s? Would that have happened naturally or was it something to do with therapy? I mean, being a therapist I would probably say that, you know, no, therapy did play a big part.</p> <p><b>Would you say that in parallel there were other things going on for you that you definitely saw as contributing to your process of change?</b></p> <p>I mean, because while I was having therapy I was also working as a therapist, you know, working with clients, and so just the experience of at the same time being a therapist and a client, you know, switching roles and working, but then for them to see me as a therapist, so I obviously gained a lot of insight just from my work with clients as well, which I think most people would do. You know, people can't help but be affected by that. So, I mean obviously that was important. I mean, over seven years and particularly at such an important part of your life, you know, because I started at sort of late 20s and went through to, you know, I am now sort of mid to late 30s, things like employment, relationships, starting a family, you know, that is all happening at the same time. So, I don't know. It is hard to say. I mean, I suppose that is why you have randomised control trials to figure out, but with this you can't, yeah.</p>	<p>Therapy as a main factor in the process of change]</p> <p>Being both a therapist and a client reinforces each other</p> <p>Personal and professional development</p> <p>Professional and personal issues as a catalyst for change</p>	<p>Learning about self</p>	<p>Comment [DC6]: agree ☺</p> <p>Comment [DC7]: I like how you categorise this one.</p>
<p><b>Yeah, I see what you mean. Could you tell me what</b></p>			

<p><b>would you see were the stages you went through?</b></p> <p>I mean, looking back in hindsight I think when I first entered therapy I was probably quite defensive, quite detached, almost sort of there, 'Well, I am here because it is part of my job' not really there for me, but there because -- I mean, obviously I was really interested, you know, and this was all unconscious. It was only later down the track as things started to work through and it was like the emotions came up and it was like, 'Wow! This is really intense' but I think the first part was probably more—I mean it was certainly more—issue based. You know, being from England I had gotten married there and then had migrated here, so all my family were in England. So it was processing a lot of that separation and the move, you know, so issue based stuff I think. And then obviously as it progressed, as it progressed over time, you know, the transference emerged and it was more about the relationship that emerged. I'm just trying to think. I mean, the real intensity came around, you know, having the loss of a pregnancy, you know, having diagnosed with a ruptured ectopic pregnancy, having to go through fertility treatment, IVF, you know, lots and lots of that. So that really increased -- And actually by that time, by the time I started all that, we had already got a really good solid relationship, and I was really thankful that I had that just so I could work through what I was going through at the time. So, once all that sort of external stuff, all the fertility treatment, started, I mean that gave a real intensity. Like, the emotions, like, the raw primitive nature of the emotions that came up were just, I mean at times, completely overwhelming. So, yeah, I mean, that was a huge part of my therapy and I was very thankful that I had an established relationship where there was a lot of trust there.</p>	<p>Defensive and detached</p> <p>Greater focus on external issues</p> <p>Building therapeutic relationship</p> <p>Very solid therapeutic alliance <i>Very solid therapeutic alliance allows very significant losses to be processed</i></p> <p><i>Emergence of the raw and primitive emotions</i></p>	<p><b>Beginning phase – Disorganization and detachment</b></p> <p><b>Emotional bond between client and therapist</b></p>
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<p>So, I think in that respect, that was another phase. And also I think that was when things transitioned to, 'Okay, I'm not here because of my work. I'm actually here for me now.'</p> <p>And I think as well it was almost like I think that was a way that I would defend myself around, 'Oh I don't need to be here. I'm just doing it because I'm choosing to because it is my profession' whereas around the whole fertility treatment and IVF it was like, 'Well, no, I really need to be here.' So, that was sort of a different stage as well. And then even sort of the ending bit, those last couple of months, it had a different feel. I found out little bits of personal information about the therapist. You know, I had a few doubts going, 'Oh, am I doing the right thing? Should I continue? Is it right to stop?' So, but, yeah, that is probably what I would say about the different phases, but I mean I would say that was triggered by major life transitions, external, but really impacting on the therapy.</p> <p><b>Yeah, it makes sense, absolutely. Now I would like to move to the next section. I would like to talk to you about helpful and unhelpful aspects of therapy. I notice that you have already mentioned some helpful things. So, would you mind me just asking again?</b></p> <p>Yeah sure.</p>	<p><i>Establishment of solid and trusted relationship as a point of transition</i></p> <p>Progression from surface to deeper level</p> <p>Emergence of more real relationship</p>	<p><b>Middle phase – From symptomatic to structural change</b></p>
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<p><b>What was helpful about the process of therapy?</b>          So, again, the opportunity to have space, you know, really small human gestures that, you know, on the surface don't really mean much, like offering an umbrella, but deeper down mean an enormous amount, so those sorts of little things. Sort of just like a real deep understanding around 'this person, so this therapist, is going to be with me', you know, 'she is here for the long haul, she is not going to back out, get cold feet, give up when it gets too hard.' So, even though it was never clearly stated, you don't sort of state that out loud, but there was a real sense of, 'we are both in this together and we are both working from the same page.' I think that developed later because I think initially there was this sense of me versus her. Like, I think that was just me, that, 'Oh, if I say something, is she going to think that about me?' or, you know, 'What is she going to think if I say this?' So there was almost that sort of feel in some way. I mean, there were things that I did that I'm sure were unhelpful, but that is part of what I think happens in therapy, and as long as you have got someone there to point them out to you, point out what you are doing to yourself, you know, I think that is really good. What else was helpful? I mean, in terms of the framework of therapy, my therapist, we got a set day and time that became my time and, you know, week in and week out that was when I had my therapy. And it was a set fee, a set negotiation around missed sessions, cancellations, so that was all useful, because I like to have all that.</p> <p><b>What was it about that that was helpful?</b>          Well, it sort of gives you a stability. Yeah, and also there is nothing unexpected. You know, just the same way that I had to let my therapist know about breaks or something was</p>	<p>Human gestures</p> <p><i>Communicating deep commitment through small gestures and little things</i></p> <p><i>Conveying real deep understanding</i></p> <p><i>Sense of deep togetherness</i></p> <p><i>The therapist as a reliable and 'good object'</i></p> <p>Secure Attachment and attunement</p> <p><i>Set rules and set space</i></p> <p><i>Secure and stable environment</i></p> <p>Strong therapeutic frame</p>	<p><b>Transforming experiences</b></p> <p><b>THERAPIST AS A DEVELOPMENTAL OBJECT</b></p> <p><b>Secure therapeutic space</b></p>
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Comment [DC8]: Hit the nail on this one too ☺

<p>coming up, 'Can we reschedule this session ahead of time?' she would let me know when she needed to reschedule a break every now and then, like, if she was attending a conference or if she was having a break. So, you know, nothing was really sprung on me. I mean, there was I think probably a maximum of twice maybe in the whole seven years where she might have called me on the morning that she was really sick and couldn't make it and could we reschedule to next week or something. And even that wasn't a rupture for me. It wasn't, you know, 'Oh, you don't like me. Why are you cancelling?' It was purely, 'yeah, of course', 'you sound really sick, and get well soon.' I think the most helpful thing was the human interaction. Also, as well, I mean obviously gradually over time allowing the therapist to see more and more of my sort of more human primitive shameful side, the part that maybe only one or two people would ever see and, you know, her not recoiling in horror and going, 'Oh, that's so horrible!' or 'How could you think that?' I mean, we know intellectually, but until you have actually experienced it, it can be very powerful.</p>	<p><i>Sense of stability and predictability</i> Predictability and availability</p> <p>Warmth and realness <i>Human interaction as the most helpful thing</i></p> <p>Secure Attachment and <u>attunement</u></p> <p><b>Therapist's qualities</b></p> <p><b>Therapist as developmental object</b></p>
<p><b>Yes, I understand what you are saying.</b> Yeah, I mean obviously there were things that frustrated me, made me maybe even angry at times. Like, sometimes, you know, I didn't always agree with how much notice I had to give if I was going away on a holiday. Sometimes I like the fact that -- Because my therapy session used to be sort of Friday afternoons, and sometimes I would think, 'Oh, let's go away next weekend. You know, we'll take Friday off work and let's go away' but it was like, 'Oh I can't, I've got therapy and that is not enough notice.' So, that would be like, 'Oh god!' you know. But for me that was the contract.</p>	

<p>That was what it was about. That's why you make the contract, so you just can't break it whenever it suits you. <b>Yes, so there is some sense of annoyance, but it is not necessarily unhelpful, or was it? Would you see it as unhelpful?</b></p> <p>No, no. I'm just trying to think. I mean, I think I have said already that I think my therapist was probably maybe more silent than other therapists might have been, so I'm not sure whether if sometimes she had have said more or broken the silence sooner that would have helped or not. Again, it is hard to tell where that is coming from. Is that coming from me or is it coming from her? Yeah. I mean, there was no real sort of technique or intervention that she did that I found unhelpful. Like, in terms of, you know, dream work, that was usually more than not useful, you know, exploring my dreams. Sometimes she would do sort of somatic body work or something like that. You know if I had a pain or just like a feeling, we would explore that on a sort of body psychotherapy level. That was always useful. I mean, in terms of face to face versus lying on the couch, because I had great resistance to lying on the couch initially, it was like, 'Oh no, I don't want to do it.' It felt really scary, but it was also helpful as well. But I always had the option. Like, if I came in one session and I thought, 'I want to sit up today' that would be fine as well. You know, I didn't have to lay down or didn't have to sit up.</p> <p><b>I'm just thinking, because you moved from sitting up to lying down. Can I ask you what brought that on?</b></p> <p>I mean, we had been talking about it for a while, you know, how would it be for me if I were to lay down, and just exploring that while face to face. I got to the point where I think I had built it up to something big, but it wasn't, I</p>	<p>Silence and time as space</p> <p>Working with unconscious material</p> <p>Active Interventions</p>	<p><b>Intra-psychic and interpersonal space</b></p> <p><b>Experiencing self at deeper levels</b></p> <p><b>Change Facilitating Strategies</b></p>	<p><b>Comment [DC10]:</b> And could this also be Model Specific interventions or Change Facilitating Strategies (about the soma and dream work)?</p>
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<p>I mean, in hindsight. And I think it was like, 'Well, why don't I just do it?' But then there was something in me going, 'No, no, don't! It feels a bit unsafe.' And then eventually I just said, 'Okay, next session', come in - - I actually think she had gone away on a break and then I said, 'Okay, when you come back I will start lying down in the couch.' Also, as well that was around the time when I had the ectopic pregnancy. I was hospitalised. You know, I was really sort of into doing all the fertility treatment, so there was a lot of intensity anyway, so we sort of transitioned around that time, I think, yeah. I mean, there were certainly times when I knew in myself, like, 'Ooh, this feels like I need to sit up today.' If I felt maybe a bit more fragile or a bit more vulnerable or maybe I wanted a bit more reassurance visually, then I sat up. And, again, there is something about lying down, because you are not looking directly at someone that you do almost have a freedom to sort of free associate and go into a reverie and those sorts of aspects. I don't know. Because I think as well people associate that lying on the couch with that whole Freudian era and there are enormous amounts of negativity and myths and stereotypes about that sort of thing. I mean, even if I think about it from a power relationship, you know, it is an unequal one, whereas two people if they are sitting in similar chairs face to face there is more of an equality on the surface. No, lying down, it was fine, yeah, and it did tend to bring out the transference more because, you know, you weren't constantly scanning the therapist's face, you know, even in microseconds sort of thinking, 'Are they going to disapprove of what I'm saying?' and you would immediately scan their face and dismiss, 'Oh no, they are fine' but that would all happen unconsciously, and on the</p>		<p><b>Model specific interventions</b></p> <p><b>Change Facilitating Strategies</b></p> <p><b>Experiencing self at deeper levels</b></p> <p><b>Comment [DC9]:</b> I'm only familiar w IPA... can this be used as an emergent theme when it has appeared as a super-ordinate theme as well?</p>
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<p>couch you don't get that. You don't get that ability, unless you turn and look, yeah.</p> <p><b>Thank you and was there anything that you could think of that was unhelpful?</b></p> <p>Yeah, I think most of the unhelpful things in therapy came from me and my own resistance or reluctance or stubbornness or whatever. Yeah, so I think that was - I mean, I'm just trying to think practically. My therapist, because she is not psych trained, there was no Medicare rebate, so maybe from a practical level that would have been helpful. I mean, the 12 sessions wouldn't have even scratched the surface.</p> <p><b>Medicare rebate, it would be something, yeah.</b></p> <p>That might have been helpful, but not really. That has just triggered something else in my mind, and I think this came from me. It is something that I imposed on myself around, 'What will people think, you know, friends, family, if they know that I have been doing therapy for seven years? I am doing twice a week' so I think general attitudes to long-term work in Perth where there was a bit of 'What will people think?' So I think I put some pressure on myself in that area. Like, I would only tell certain people who would have understood that that is what I was doing.</p>			<p><i>Cost of therapy</i></p>
			<p><i>Fear of being judged for undergoing a long term therapy</i></p>

## APPENDIX F

### RESEARCH'S INTERVIEW- EXTRACT

**So, maybe you could tell me a bit about your occupation and what you do.**

Well, I'm a student, but I should probably say I'm a psychologist. I'm a registered psychologist.

**Okay. And you are from Poland, right?**

Yes.

**I mean, this is about therapy; this is just to get us into the mindset of that. I understand you have been with a therapist within the last six months. Did I get that right?**

Yes.

**Has there been any previous experience?**

Yes, it has been ongoing for the last three years, on and off, with the same therapist, so, yeah.

**Okay. So it has been the same person?**

Yes, yeah.

**And is it still ongoing?**

Yes, which it shouldn't be for this research. I'm talking to people who have actually finished, yeah, but because we are testing it, it doesn't matter.

**So, maybe if you could tell me a bit about your therapist that you worked with, what is his or her orientation as a person like?**

I actually don't know. I know that sounds strange, but she doesn't seem to fit into any specific school. I would say she may be somewhere between existential and, not really psychodynamic, no. Honestly, I would struggle to put her in any particular orientation, yeah.

**That's okay, yeah. But from the little that you understand, it is dynamic, it is existential, but not - -**

Not necessarily from the way she works with me, but I guess her philosophy would be around - - And I suppose with an existential approach there isn't really much of a technique that you are using, so, yeah, let's just kind of loosely assume that she is existential.

**Sure, that's fine. So, I am going to start the interview process with you but feel free if along the way you view some questions as a bit sensitive and you don't want me to go much further, just stop me there.**

Yeah.

**Is there anything you need to do now to just prepare yourself to recall and remember these things?**

Not really. No, I don't think there is much I could do at the moment. We'll see how much I can recall. That, in itself, will be useful to know.

**Okay. So, maybe if we could just start generally, if you could describe your experience in therapy.**

Just because we started and we stopped and then I went back, so I have this in different segments, if you like. So, for me, going to the very beginning, well, first of all when I started it was more to do with supervision. I was looking for supervision, so I didn't treat this as personal therapy. It was more additional external supervision I needed at the time.

**External?**

External, because of what was going on at work. So, let's say the first couple of months of therapy was more around supervision really, work related issues. So, I wouldn't necessarily include this because then it changed. We focused on me and it became a personal therapy, and that is maybe what I would talk about.

**And that was what you wanted?**

Yeah. I guess it is hard to describe this in one way because there have been so many things going on. I don't feel like describing it in terms of being positive or negative. It just doesn't feel right to - -

**Put it either, okay. What about fit? How would you describe it?**

It has certainly been useful, challenging. Maybe because I'm still in it, I didn't have a chance to actually digest it and look back. Maybe what I'm about to say will sound strange, but because I'm still doing it for me what became extremely important, and I don't even understand why, is to stay away from naming any of the experiences that are happening for me in therapy. Like, I'm trying not to lock it in any description.

**By just saying it?**

By saying what it means or how it is done or what it feels like, and that is probably a lot to do with what is currently going on for me as a result of therapy, yeah, where it just doesn't feel right to call it anything, you know. And I don't understand this myself, but I have an immediate reaction when I try to think, 'Okay, so how would you describe this?' There is one way of looking at it, which is consistent, I guess, from the beginning for me, something that didn't change. It feels like drawing a map. It is like discovering some space, some new place, it is very hard work, but it feels like finding different roads, if you like. Yeah, that's what I would maybe see as more of an accurate description, but even then I just really don't know. I can't - -

**Can't quite pin it down, but the parallel of as if drawing a map to - -**

Yeah, it is as if I have been given a map or someone is preparing me or trying to guide - - Well, I suppose a guiding element is in it, but it is more of me just going and discovering something and then trying to process it and maybe somehow put boundaries around it, yeah, and exploring it, yeah.

**Okay, okay, that's fair enough. I know that in the process there will be sort of a push to almost name it in some way or another - -**

I know.

**But I wonder if you look back at the three years or even as it is ongoing, how do you feel you have changed as a consequence of the work in therapy?**

Let me think. I'm not aware of any changes that are obvious to other people who interact with me. In terms of me subjectively experiencing it, I think the major thing is that I was able to shift from staying in my head, really experiencing things by intellectualising. I think therapy in some ways - that I don't even understand myself how- led me to be more aware of the emotional side of things first rather than being removed from it and just talking about it. I think that's where I am at the moment in terms of change, and that has been quite a significant shift.

**It is a result?**

Yeah, as a result of it I can start from emotional and then even make a choice of not making it intellectual but just staying in that space, which is something that I never aimed for. It wasn't on my agenda in terms of going through the therapy. And it surprised me. It just, yeah, I didn't try to get there. I feel like I just didn't know that I could, yeah.

**Right; and that is different for you?**

It is very different, and it is scary at times. It changed everything really, but I think it is too early because this shift - - Or perhaps I became aware of it recently so it is too early for me to say much. It is so fragile that I don't want - - It is almost, I had this moment a few days ago when I was walking and suddenly it is not that I think about it. It is more that I feel something, and it is becoming - - There is a visual component to it. I try to stop my head from interfering, if you like. I want to live it, because I don't exactly know what it is yet. So that is where I'm becoming very careful, and I think that is the most significant and profound thing that happened to this point in therapy and that is quite recent.

**Okay, okay. Instead of trying to intellectualise it or something, you want to take care of it and make sure that it is taken care of?**

Yeah, I want to allow it to stay there without trying to name it or understand it or quickly lock it into something, make something out of it. I don't want to do it.

**Okay. I mean, it is also not entirely fair for you because this process of interviewing you know is only for people, I guess, when they complete.**

Yeah, so maybe I'll try not to go into much detail in terms of that stuff, yeah?

**That's okay. I think it is going okay. If you were to make a comparison, how much of the improvement or things that are evolving or changing and growing are due to therapy or other factors outside?**

I think it is mainly due to therapy, having someone who is always there without putting any pressure and just waiting for me to do what is right.

**In your own time?**

In my own time, absolutely, yeah.

**And is it right to assume that that is something you appreciate?**

Yes, absolutely!

**It is a bit odd to ask you this, and feel free to say that you may not be clear, but how do you think these changes come about?**

Maybe I have already started talking about it in terms of what my therapist is able to do for me. I don't get a lot of direction. There is not much agenda on her part, but there is a safe environment. I guess that is the most important thing for me. I feel like, there is an enormous trust in me and an enormous trust in my ability to go much deeper than I even consider, I guess.

**So she trusts you?**

She trusts me a lot and she is not pushing. She is waiting for me to be ready. If I need to withdraw, that's fine. We are sort of going with that without knowing how long this is going to take or where it is going, I guess. It is more about preparing. It is almost like preparing that ground for something to plant in and then wait for what is going to happen, and I think that is what she is doing. And it can irritate at times, because you are sort of thinking, 'Okay, I can't take it every week, I want some structure. I want someone to tell me this, this and this' but looking back at what was going on for the last three years, I appreciate this because the changes are coming. I know they are purely to do with me and they are not because something was imposed or suggested as a good way of being, as changing from one sort of way to



another that was borrowed from someone else; I don't get that sense, no. I know it is really coming from me. I'm making myself out of myself, if you like.

**Sort of like you can't force a seed to grow up or pour too much water to hasten the speed. It was from you and she just nourished and nurtured you that way.**

Yeah, and she is sometimes using this metaphor of a pregnancy where you can't speed up this process. You just have to wait, and this is what's going on, and I guess that's how we are working.

**So, the process of which is something that is nurturing and it can't be rushed and it has got its stages of development. Is that right to put it that way?**

Yes, absolutely! That's it; that's what is happening.

**Okay, this moves to the next question but it is related to what you said. So, is it fair to say that what was helpful were the things that you mentioned about the safe environment, not like as if she is taking some other approach to force-feed you in?**

Yes, absolutely!

**Now, let me just go to the flipside. What was unhelpful then?**

See, again, there are some aspects that at times I find challenging and frustrating but it is mainly because I just want something artificial. I want something external to be given to me so I can just relax and not feel - - I would like to speed up the process sometimes, but she is not giving me that. But that is, at the end of the day, not unhelpful but helpful. It is getting me where I want in the long run, but at a given moment I can think, 'Oh god, no more' but there are some things in terms of what she is doing that I find unnecessary. First of all she takes notes as we are interacting in sessions, and I don't like that.

**Like what I'm doing now?**

Yes, yeah, except that you are interviewing me, yeah, and she is - -

**But it is therapy?**

Yeah, in therapy that is not what I would expect, but she does it and I kind of, you know, try to ignore it.

**You try to block it out?**

Yeah.

**You have never brought it up?**

I did initially say it, and there were certain sessions where it was more to do with supervision when I just said to her, 'I wouldn't feel comfortable talking to you about certain things knowing that you were writing it down' but it was more around not wanting her to write something down. But I didn't raise the issue of, 'Please don't take notes while you are talking to me.' That would be more specific.

**If I hear correctly does that mean you don't like her to take some specific things down?**

No, that was in the past where there were certain things I felt she shouldn't write down because it was to do with work, but what I don't like her doing in general is writing while she is in the session with me. I kind of got used to it over three years.

**You are very accommodating.**

Sometimes she talks about herself. She is giving some examples, and it is not necessarily self-disclosure as such. Sometimes it is useful. But she tells stories and maybe at times I see the value of it, but a lot of the time I get really impatient and I just want to say to her, 'Please stop', although I don't say it, but the way I feel is 'It is my time; I want this to be all about me. I don't want your stuff being brought into it'.

**Is it her stuff or other stories or both?**

It could be both. It could be both, yeah. And sometimes, as I said, it is very useful, but most of the time is not.

**Okay, so, I mean, it is kind of like using your time?**

Yeah, exactly, and that is how it feels. I'm just looking at her clock and thinking, 'Oh! No!'

**Is there anything else, anything else that crosses your mind that you have to accommodate?**

Something else that I wish she was doing more, working with me by utilising our interaction, so really bringing it to here and now, and also maybe enquiring now and then about my feelings towards her and all that. That is the missing bit.

**That means missing totally?**

Totally, yeah.

**I see, and you would have preferred if that was - -**

At times certainly, yeah, especially when we talk about the way I present to the outside world, I suppose, and the way people respond to me, the transference/counter-transference stuff. I think it is very relevant and it would be very helpful to have it with her, whereas I think doing groups, and currently we have just started a group, and of course this is a perfect place to look at this, you know, how people are experiencing you and so on, but it is less safe, in a way, for me than it would be in one-to-one therapy. And I don't get that, so this is something that I certainly consider important and it is not there.

**Okay, thanks for that. As you recall back to the sessions you have been, without giving too much thought, is there anything that sticks out, any significant moments within your work with her?**

Well, yeah, I think I had a lot, a lot of important moments, and the best way, I guess, I could talk about it - - It almost feels a bit silly because as I'm saying this to you now I'm thinking in the next few days I will be sitting on the other side hoping that people will give me that secret recipe, and I can tell you right now you will be disappointed to hear my response, because there isn't anything that at least I could offer as, something that is specific enough for someone to take and replicate. The way I would say it, and it may not make much sense and I don't necessarily feel as though it makes a lot of sense to me, the moments, there were a number of moments that I consider extremely important because at the time I felt as though something was unlocked or something moved from one place to the other, something was able to go deeper, whatever it was. It is a very strange thing to say, but how this came about on a number of occasions, well, this is something that is going to be disappointing to people to listen to later, because the best metaphor I could use would be - - I don't even know if that is good. I don't know if a metaphor will help. It is like with music when it is in tune it is the right amount at the right time and nothing is colliding. It is just that right space.

**In harmony?**

Yeah, in harmony, and it could have ups and downs, and I'm not talking about those. I'm talking more whatever elements you have they are not off line. They are centred, and I think that is what happened every time when I believed I had an important experience in therapy, it was just natural. She said things to me in response to what I was saying which were just perfect at that time. It is not about what she said. It is when she said it and how she said it. Essentially we are talking about timing.

**Yeah, yeah, the context?**

The context; I guess there must be a few elements there, and something that was just a notch higher than where I was situating myself, but just tiny bit. Not too much, not

too little. But, you know, it is really vague what I am saying. It is very abstract and I can't pin it down to anything specific, but that is the overall feeling that is consistent, I guess, through every moment that I can recall.

**Wow! So you witnessed this happening whenever you considered an important significant moment?**

Yeah, yeah, and she would ask certain questions, although she does very little of it, which is also a very good thing. You know, there is no bombarding you with questions or doing follow-up from previous sessions - - I probably shouldn't jump, but this is something else, that she would never, unless it was something extreme, but generally the opening of the session is not her going through her notes and, 'So, let me just remind you what we were talking about last time' because for me it would be like, 'Oh no, I can't do it, because I'm coming here new, with new ideas, and previous might not be relevant and if they are I will bring it into the conversation.'

**Right, you would do it?**

Yes, yeah, so in that sense, I mean, it is always driven by my agenda and not by her agenda and for that reason it is more relevant and I can be excited by it and stay focused. And also important moments, this is the other thing, they energise me. It is a mixture of curiosity and excitement and even when sometimes what you are discovering is painful, but that is also one of the elements, consistent elements, of these experiences that I have had in therapy with her.

**Okay. Can you recall any moments where you left thinking or feeling differently after your session about a situation or about you?**

In the last few weeks I would say actually every single session. I think now is a particular period of time where there is a lot going on in therapy so it is kind of expected. I'm not surprised by it, yeah.

**Have you experienced any empowering moments in therapy?**

Yeah, and they are also linked to what I was saying previously that that sense of empowerment that I get from the significance of what is happening, but I can't really separate it. It is overlapping, you know, with this element. It is just really - -

**It is not like you can pick out the ingredient?**

No, no.

**Did therapy provide any opportunities for new learning of experiences or any learning through your experiences?**

Yeah, I would see the whole experience of therapy as an ongoing learning for me, but I don't get any specific moments that I take as, 'Wow! That is a huge learning experience.' No, things don't happen that way for me.

**And you are saying that it is not something that you intellectualise or understand rationally? It is here? It is all - -**

Yeah, and more so now, and I consider this far more important than something that was going on - - In the past in therapy there was a lot of, I would say, preparing ground for something real, which basically was months and months and months of using intellect, talking about stuff - -

**This level?**

Yeah, it doesn't take me anywhere really. At times it helped me to manage anxiety. That was what I was capable of at the time, so she wasn't pushing me to do anything else. So, at the moment I'm sort of thinking I don't necessarily want intellect to come into it because I feel like it is going to contaminate what I have now, and there will be time for me within the next few weeks or months to process this experience and place this somewhere in my head.

**Yeah, but not now.**

At the moment I just almost feel like I will be sabotaging this process for me, if that makes sense. Like, I can have images but I can't get into talking about it in a certain way. It feels like it belongs to a different realm. It is almost like you would have to design a new language to describe this. It feels so new to me.

**Yeah, and we shouldn't; we shouldn't try and do that at this stage at the moment. I guess a curiosity of mine that came about as you were saying that, how come you value more growth this side, I mean, to experience that here?**

Because I have never had it before, yeah. That is very new for me. That is a very new experience and I never really thought it was even possible.

**Oh! So is the difference - -**

Even in the way that I am experiencing it now, yeah. So, I value it that way.

**So it is a difference that makes the difference?**

Yes, yes, absolutely!

**I mean, based on what you were telling me of your work with this person, how do you think you were using therapy, to grow or to develop or to change or even to accept?**

Well, maybe I will start with something really basic. I try to really maximise my involvement in this process in terms of what I'm doing with each session, the hour that is there for me, and I'm trying to pack this with so many things, and at times it is just a ridiculous idea. How I'm using it, well I'm doing all sorts of things. It is difficult to - - In a way I think now that I am moving, this is something I can't stop. There is something profound going on for me at the moment and there is nothing I can do to stop it.

**You can sense that?**

Yes. So at this point in time I'm using therapy to contain it when I need it, to still have some boundaries in place and necessary defences so I can go on with my life. I can be externally whole. I am in terms of, you know, going to school and doing my work, so here I'm not falling apart, but at the same time because of the enormous changes that are taking place it feels like I'm almost fragmented. I know someone may say, 'Oh my god! The DSM is needed here because something is going on' but, no, it is such that you take yourself apart in order to put yourself back in a different way. So, how I'm using therapy to do it, because I can talk about it to someone who has an understanding of it and can see it further than I can, can keep me there without experiencing so much fear that I would withdraw and, you know, I would say, 'I can't take it.' Of course, if it is becoming too hard then we are slowing down, but generally I get that encouragement that it is great and everything will eventually fall into place. I don't necessarily use therapy in the sense that I go there and I want some evaluation of what I'm doing. I don't know; I don't even know how to answer this question.

**If I could put it another way, some people will go into therapy to solve or resolve some marital issues, some people will go for some work issues, some people go there for some sex issue.**

Oh okay, in this way, in this sense, no, certainly that's for me a secondary thing. There are issues there and I am kind of thinking I'm not targeting this level, because they are evident, and I have the relationship difficulties and so on, but this in itself pushed me to look deeper and that is where my focus is. We don't necessarily talk a lot about the practical side of it. That is not the main focus here.

**That is not the important thing. So, you are looking deeper in -?**

I'm just trying to understand. I suppose I'm trying to get a better sense of what is behind my decisions, what is that deeper side that drives it, and we are trying to figure out that part that kind of fuels everything else. And on different levels there are different issues. I can talk about what sorts of things I do and a lot of them are quite dysfunctional. So I can focus on that. But, we are sort of skipping that very quickly and going deeper, but mind you that is not how it all happened before. I think that is recent. Yeah, I think in the last few weeks maybe it is happening more so than before.

**Okay, so there is a bit of change in the approach as well?**

Before we were talking about it just, you know. It was more the intellectual side of it.

**Okay. And if there was any point where you disagreed with her -?**

I would just say it. The only times, I suppose, when that happened is to do - - I bring a lot of dreams into therapy and we work with that. I find that very useful, very helpful, and sometimes she is rushing with some interpretation and then I will just simply stop her and say 'No, it is not because it doesn't resonate with me at all.' So, yeah, I communicate that directly, yeah.

**Good. It does strike me that one of the things that keeps coming out in the theme of this work is you seem to know how you want to grow?**

Yeah, and I think in many ways I communicate this in therapy and what I get from my therapist, which is extremely helpful, is 100 per cent support for how I want to go about it. This is what I was trying to say earlier about the map, you know. I am kind of finding a way of how I want to draw it and where I want to go with it and she is following me and giving me enormous encouragement to do it.

**I like that. I like the way you put it. This is 100 per cent the way you develop the terrain and how you create the map and how you formulate the way you are going.**

Yeah, and sometimes we need to stop and build something, I guess, and need to destroy something. There are all sorts of things going on, but it is driven by me, and in a way I find this difficult, but I always know that she is there. She is there when I need her, and when I need her to say things to me. Sometimes there are periods of time in therapy where what I value the most, I guess, is for her to say, 'You are not crazy! Things are going to get better. You are doing the right thing.' That's all. And sometimes I ask her to repeat this 15 times in the session, because I want to know.

**To be affirmed of what you know?**

Yeah.

**I mean, were there things that you withheld that you - -**

Oh yeah! Wow, a lot! And this is going to sound crazy, but I withheld, I guess, the most crucial information, or I managed to avoid talking about for almost two years, and that was my kind of warming up into therapy and trusting my therapist. There were a number of issues and reasons why I didn't, because I wasn't ready to deal with it, and she knew. I mean, from being my therapist for two years, she knew what the issue was. She just knew that I'm not ready to tackle it or talk about it or do anything about it, so we just left it. But, yeah, I withheld quite a bit. I couldn't - -

**You couldn't?**

I couldn't see the point. I was totally not ready to do it. Maybe it was four months ago that I decided that I'm kind of ready to talk about it and so I did.

**You decided?**

Yes, absolutely! It was on my terms. She would never - - You see, this is it. I guess she formulates some ideas about me, but she would not sit across and say, you know,

'Help me understand this because you have never mentioned your mum or your dad. Can I get some information on that?'

**'No.'**

'No, no' because if I gave her this information it would be in the wrong time and the wrong place. But, of course, she was aware of certain things that other people would consider very problematic and certainly would try to get into it, but she didn't, and she just once mentioned a book she read which kind of alluded to it and she started telling me about it and I sat there with no reaction, and she dropped it. So, that was that, and she never went back to it. So, it was very oblique, but, you know, she would never - -

**If she didn't do that, if she did - -**

Oh, if she said - -

**Yeah.**

I can't tell you whether I would stay or whether I would leave, whether it would be helpful or not, because that wasn't my experience. What I can say is that because she didn't, she did ten times more for me in the long run. And I'm not saying this is a recipe for a therapist to avoid talking about it. It is a specific situation, my situation.

**For this situation, this time?**

I was avoiding this issue in my life. It didn't stop me to function as a normal person, going to do my PhD and so on, so we are not talking about someone who was falling apart and the therapist saying, 'You don't want to go there?' 'That's fine'. No, it is not quite the same, but because she allowed me to do it on my terms and when I was ready, when I became ready the issue was in the right place at the right time, and that is something that if you get to experience, you know you can't compare this to anything else. It is a mixture of being terrified - - I remember exactly when it started and I thought, 'No, I'm going to stop it because I managed to put brakes on it before and I'm going to do it now.' And I suppose I could have done it. It would have taken a lot more effort than it did in the past because obviously the issues were becoming bigger so you need to try harder to suppress it. And I still knew that I can at any point come back to see her, and we always made this clear, that when I feel like it is relevant I can just go back. And when I tried to suppress it there was this other part where I thought, 'No, this is just too exciting.' It was just bizarre, but I think because it was happening on a different plane, it was not just in my head, so that was what just swayed me to go with it. The build-up to it, we are talking four years or five years build-up, plus everything that happened prior to this.

**And as a result of you taking that step -?**

Pretty big things are happening for me right now, and I can't describe them in terms of good or bad. I think they are necessary, you know. I don't do them justice by placing them in any category.

**I guess what I'm trying to say is not so much as what is it like now, this way, but what is it like now to be able to take that step, that risk?**

Well, it is a mixture of feelings for me. I'm angry at myself, and angry at everybody around me. I feel like something is growing that I don't understand, don't have control over. You don't feel comfortable with it. It is odd, but I never questioned whether that is the way things should be.

**Sure, but you said it was necessary?**

Yeah, yeah, it was necessary for me.

**How come?**

Necessary because I think I was getting to the point where intellectually I was prepared, I was aware enough to almost force myself to make a decision. I knew that

I could go ahead with my life, which would be fake, or I could take that road, which I didn't know what is going to - -

**Happen now.**

And how and what, but I knew I had to - - And I think she played an enormous part in all of this, because I knew I could count on her. I knew I could always come back. And I knew she would help me with it. And it happened, so the intellectual side, you know, the first two years of just talking about myself and others but really not having any kind of awareness on any other level but my head, was necessary because it placed me in the right position. It made me comfortably enough uncomfortable with myself where I could just see the risk of being what I was and was becoming, and also equally becoming aware of some other options, and that was what I think was happening. But that was the preparation that took some years, two years in therapy.

**I mean, this may not fit totally to you but the thing that really struck me about what you described about comfortably being uncomfortable and that way, it sounds so strikingly to what you said earlier that this is about growth, because growth isn't always a good feeling and comfortable. It can be painful.**

Yeah, it is and it is not, but there is some space already prepared for it, you know, where this can happen and I think that is what is important. I want to use a metaphor... It is even to the point that with her working with me I was allowed to choose which garden I was going to do it in. I was allowed to make the pot myself. You know, I wasn't planted where someone else thought I would grow really well, yeah. So that is what is happening here and I think it is extremely useful to me and I don't think it would have such an impact if it was done in any different way.

**She really has faith in you. I mean, prior to you starting the work with her, moving onto E, did you have some kind of understanding or explanation in your mind or even if you talked to somebody on what was causing the problem there, I mean, if we could define it as a problem?**

I don't know. What I certainly had in mind when I started working with her is who I wouldn't like to work with and what sort of strategies wouldn't work on me. So when I went to see her I was really clear from the start - -

**You were clear?**

Yeah, in terms of small things. I didn't necessarily say, 'I want existentialist' or this or that. I said to her, 'I certainly don't think that a CBT model is going to work with me, so please don't give me any homework. Please let's just not evaluate my thoughts and link them to my feelings, because I'm not going to work in this environment real well. I know myself. That's not how things will be activated. It will just irritate me and I will - -'. So she said, 'That's fine and that's not the way I work anyway, so I wouldn't do it.' So, you know, it is a very difficult question because I guess it is communicating all of this, and I communicate this all the time in sessions, and I think every client in therapy is able to, and I believe that most people actually do say how they want to work. It may not be as overt, in a way, but I think you are getting it all the time from people. In terms of the origin of their problems I think you are also getting it all the time, directly and indirectly, and I think for me she was able to go with it - may be because I was articulating it. I certainly wanted her to be very supportive, but I didn't want her to impose any preconceived ideas about how to work with me, because that wouldn't work. I didn't want this. I would feel suffocated and it would contaminate the process, so she went with it. I can't say what she is like when she works with other people.

**It might be different.**

Maybe she will take their idea of working and run with it, yeah. So, in terms of what was causing the problem for me I think there are many explanations. I think that the most important one which we talked about is to do with attachment, you know, my very early experiences and my relationship with my mum. I think in my mind that was a profound experience and of course the early experiences are, but we never directly worked with any of this. I don't remember ever connecting it, like, 'So, yeah, now you see how feeling or being afraid of rejection is linked to that sort of emotional deprivation originating from this.' That never happened, so what I'm trying to say is that I don't think that this played an important part in the whole process, but certainly my idea of how to work, I think it did.

**So, clients do say it overtly or not overtly?**

I do think so and certainly this is what I'm doing. Even by saying to her, 'I don't know where to go. I don't know what to do. I want you to tell me' I'm still communicating something, yeah?

**So it is the job of therapists to pick that up and fit in?**

Absolutely! Yeah, because I think only by doing it that way you are making it possible for someone to discover who they are, to discover a new place. You are not trying to take them to the place that you believe is suitable for them, or, yeah, where you think they will be comfortable.

**Right, so to become who they are, not so much who they should be?**

Absolutely!

**Even if the therapist had the best of intentions?**

Absolutely! And thinking that they have fabulous - - There is this fabulous island and I can promise you that if you can get there you will be happy' you may be for a very short period of time, but it doesn't have that depth, so nothing there would resonate because it is not made by you and it doesn't come out of you.

**Yeah, but what is so powerful about it coming out of you? I mean, like, is it an empowering feeling or is it just an ownership of it?**

Just when you asked me that question, I had a feeling and it is gone, but, no, I will just have to think. There is a way I could answer this question at the moment. I am thinking how to do it. Well, apart from just saying that there is probably nothing else worth doing in life than precisely that, for me, but what it does, when you have it, I think, and I start getting glimpses of it—it didn't fully emerge, so it is happening—but the little bits I have are giving me the sense of being authentic and alive. It is very strange. It is something solid. I think it is you essentially. That is what it is. It is not you made out of different kind of external things or what you believe you should be and all that.

**Something real?**

Yeah, it is real, but because it is real it can be so many more things throughout your life and you know you can rely on it always. I think that is the realness of it that it can become what it needs to become. It can be flexible and it may not. I think it is what sustains you and when you in it, you know it. Yeah, so I think there will be no enormous concern around, okay, what in the next five years? Of course, there are problems and you deal with them, but they don't shake you to the core. I mean, there is something there.

**I mean, I hear your struggles between saying flexible and not flexible because it doesn't quite do it for you. It is something that you could shape anything and everything to become because it is from within.**

But it is equally at the same time not malleable. Like, you can't really simply change it or influence lightly because - -



**It is quite solid.**

This is very solid, but at the same time equally malleable. I mean, you can do lots of things with that, so it has those extremes. Yeah, it doesn't constrain you in any way. You can do different things with it. That is the kind of sense I'm getting, but tiny bits of it because for me whatever is happening has just started happening. I think it is going to go for a long time.

**I have to admit this last part is the first time I have heard anybody explain it that way. So, I think it is useful to think of it in that sense, for me at least hearing from you, because most of the time we just think, 'Yeah, it is flexible; it helps you do more' or 'it is really concrete' but it doesn't seem to be either? It seems more than that.**

More than that.

**I think it is still helpful to explore in that way, but I think for me as an interviewer the main thing I'm hearing really loud and clear actually—I might be deluded—is the idea of the growth philosophy. It is not something you could tweak technically and then sort it out with a mechanic. It is really like a seed, but you have got to be careful or you have got to take care that no strong winds blow it away and it is always going to be constant and consistent. At least from your story it does sound like that.**

Yeah, because I'm thinking that is probably what I told you, but I can't imagine that everyone will be talking about it that way, because for some people it is very different.

**No, they won't. Some people, 'I want you to just fix me up really quick'.**

Yeah, yeah.

**I do have a last question, though, and this is just out of curiosity - -**

**As the person being interviewed, were there parts that you had difficulty disclosing to, say, a new person, because I imagine if you are talking to people that you may not have known?**

Not with you I didn't. I didn't really omit something I thought, 'Mm, that is very relevant to this but I'm not saying.' No, no.

**But it turned out rich. It turned out really rich, you know.**

It turned out better when I think that way.

**But it is strange. It is also at the same time I'm learning. I mean, even though I'm interviewing you, I am learning about, yes, about helpful and unhelpful or whatever the therapy has been, but it is helpful for me in the way that it goes, like, 'Boy, just don't be tempted to pin it down.' Just be not just open, but willing to embrace anything that comes into this - -**

Yeah, and just watch, but then you know, of course, with different clients there are different things, but I'm looking forward to starting the interviews because I think it is going to be extremely fascinating to sit with someone and listen to their story and how they experienced something.- - *(End of audio file.)*